ILLINOIS DEPARTMENT OF PUBLIC HEALTH
ESF-8 PLAN:

BURN SURGE ANNEX

November 2016
Public Version

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Attachments

ACRONYMS/TERMS

AAR	After Action Report
ABA	American Burn Association
ABLS	Advanced Burn Life Support course
ACS	Alternate Care Site
APA	American Pharmaceutical Association
APN	Advanced Practice Nurse
ARC	American Red Cross
ATS	Alternate Treatment Site
CEMP	Comprehensive Emergency Management Program
CEOC	Commonwealth Emergency Operations Center
CHUG	Collaborative Healthcare Urgency Group
DPR	Division of Disaster Planning and Readiness
ED	Emergency Department
EMAC	Emergency Medical Assistance Compact
EMS	Emergency Medical Services
EMTrack	Commercial electronic multi-functional tracking system
ENA	Emergency Nurses Association
EOC	Emergency Operations Center
ERC	Emergency Regional Coordinator
ESAR-VHP	Emergency System for Advance Registration of Volunteer Health Professionals
ESF	Emergency Support Function
FEMA	Federal Emergency Management Agency
FGM	Fiscal and Grants Management
GLHPP	Great Lakes Healthcare Partnership Program
HAv-BED	Hospital Available Beds for Emergencies and Disasters
HAM	Amateur radio
HBPPC	Indiana State Department of Health, Hospital Bioterrorism Preparedness Planning Committee
HICS	Hospital Incident Command System
HPP	Hospital Preparedness Program
IA	Iowa
IAACCT	Illinois Association of Air and Critical Care Transport
ICAHN	Illinois Critical Access Hospital Network
ICEP	Illinois College of Emergency Physicians
ICU	Intensive Care Unit
ID	Identification
IDPH	Illinois Department of Public Health
IEMA	Illinois Emergency Management Agency
Illinois ENA	Illinois Emergency Nurses Association
Illinois Helps	Illinois ESAR-VHP Program
IMERT	Illinois Medical Emergency Response Team
IMT	Incident Management Team
IN	Indiana

IPA	Illinois Pharmacists Association
ISBE	Illinois State Board of Education
ISMS	Illinois State Medical Society
KY	Kentucky
KYEM	Kentucky Emergency Management
LHD	Local Health Department
LTC	Long-term Care
MACS	Multiple Agency Command System
MCI	Mass Casualty Incident
MDHSS ERC	Missouri Department of Health and Senior Services Emergency Response Center
MI	Michigan
MO	Missouri
MOU	Memorandum of Understanding
NIMS	National Incident Management System
OPR	Office of Preparedness and Response
PA	Physician Assistant
PCMS	Pediatric Care Medical Specialist
PHEOC	Public Health Emergency Operations Center
PHEP	Public Health and Emergency Preparedness
PHMSRR	Public Health and Medical Services Response Regions
PICU	Pediatric Intensive Care Unit
POC	Point of Contact
POD	Point of Distribution
REMSC	Regional Emergency Medical Services Coordinator
RFMR	Request for Medical Resources
RHCC	Regional Hospital Coordinating Center
SBCC	State Burn Coordinating Center
SEOC	State Emergency Operations Center
SIRC	State Incident Response Center
SIREN	State of Illinois Rapid Electronic Notification
SMOC	St. Louis Medical Operation Center
SNS	Strategic National Stockpile
TAC	Trauma Advisory Council
T and E	Training and Exercise
TBSA	Total Burn Surface Area
TMTS	Temporary Medical Treatment Stations
WHEPP	Wisconsin Hospital Emergency Preparedness Program
WI	Wisconsin
WI-TRAC	Wisconsin's Hospital Available Beds for Emergencies and Disasters

RECORD OF REVISIONS

DATE OF CHANGE	SECTION(S) UPDATED	DATE POSTED
January 2015	Original document finalized	January 2015
November 2016	New additions to Annex: 1. Attachment 1: Overview of the Burn Surge Annex 2. Attachment 9: IDPH and SBCC Communication Process 3. Attachment 10: IDPH and SBCC Communication Process Algorithm 4. Attachment 16: Distributing Burn Patients to Trauma/Non-Burn Hospitals 5. Information on the American Burn Association Midwest Burn Region (See sections 2.3.3, 2.2.3 and 3.2.9) Additional changes: 1. Section 2.2.3: Clarification of communication pathway and Request for Medical Resources Process 2. Attachment 6: Burn Communication Pathway updated 3. Section 2.2.4: Language added to address new Attachment 9 and Attachment 10 4. Section 2.4.1: Clarification for how EMTrack electronic patient tracking system assists with reunification 5. Separating Burn Triage Guidelines into two separate attachments (Attachment 14: EMS Burn Triage Guidelines and Attachment 15: Hospital Burn Triage Guidelines) 6. Section 2.4.2: Language added to further clarify the process of using the Burn Medical Incident Report Form to assist with patient transfer coordination 7. Attachment 5: Burn Medical Incident Report Form updated 8. Section 2.4.5: Language added regarding ongoing burn education requirements 9. Section 3.2.2: Language added to further clarify the process for using Attachment 13: Burn Patient Tracking Log, Attachment 23: Burn Casualty Communication Log and Attachment 24: Post Event Data Collection Log	November 2016

PRIMARY AGENCY

Illinois Department of Public Health

SUPPORT AGENCIES AND ORGANIZATIONS

Illinois Emergency Management Agency
Regional Hospital Coordinating Centers
EMS Resource Hospitals
Hospitals with Burn Capabilities
Trauma Centers
Hospitals
Great Lakes Healthcare Partnership (IL, IN, MI, MN, OH & WI)
Additional Border States (Kentucky)
American Burn Association Midwest Region (IL, IA, KS, MN, MO, NE, ND, SD &WI)
Illinois Critical Access Hospital Network
Illinois Helps
Illinois College of Emergency Physicians
Illinois Emergency Nurses Association
Illinois Department of Human Services
Trauma Advisory Council

1.0 INTRODUCTION

1.1 PURPOSE

The purpose of the Burn Surge Annex is to support the Illinois Department of Public Health (IDPH) ESF-8 Plan, by providing a functional annex for all stakeholders involved in an emergency response within the state of Illinois and/or adjacent states in order to provide appropriate burn medical care to patients in Illinois during a burn mass casualty incident (MCI). This annex guides the state level response and provides local medical services guidance on the care of burn patients, including patient movement, recommendations for care and resource allocation during a burn MCI that overwhelms the local health care system. This annex is intended to support, not replace, any agencies' existing policies or plans by providing coordinated response actions in the case of any type of burn mass casualty incident. The Overview of the Burn Surge Annex (Attachment 1) provides an algorithm reference for the overall components and processes outlined in this Annex.

1.2 ASSUMPTIONS

1.2.1 The IDPH ESF-8 Plan has been activated, either partially or fully, at the discretion of the Illinois Department of Public Health (IDPH) director.

1.2.2 The Public Health and Medical Services Response Regions (PHMSRR) (See Attachment 2) serve as the primary regional geographical organizational structure for the IDPH ESF-8 Plan and the Burn Surge Annex response.

1.2.3 The local and/or regional health care system has exhausted their capacity to care for burn patients and has implemented and exhausted any mutual aid agreements, therefore requiring assistance from the other regions and/or the state.

1.2.4 Requests for assistance from the State Burn Coordinating Center will be considered once a Request for Medical Resources (RFMR) has been made as outlined in the IDPH ESF-8 Plan.

1.2.5 In the initial stages of a mass casualty event that includes large numbers of burn victims; all hospitals may have to provide care to burn patients until adequate resources become available to allow for transport to a hospital with burn capabilities.

1.3 SCOPE

The Burn Surge Annex is designed to provide the command structure, communication protocols, RFMR process, and the procedure for inter-regional and interstate transfer as related to burn patients. The Burn Surge Annex is designed to:

1. Enable safe burn patient transfer decision making.
2. Implement standardized care protocols as needed.
3. Ensure associated communications processes are in place.
4. Support the tracking of burn patients throughout the incident.
5. Assist with the coordination of transferring acutely ill/injured burn patients to hospitals with burn capabilities.

The Hospital Preparedness Program (HPP) capabilities addressed in this annex include, but are not limited to:

1. Health care system preparedness
2. Emergency operations coordination
3. Medical surge

The Public Health and Emergency Preparedness (PHEP) capabilities related to this annex include, but are not limited to:

1. Community preparedness
2. Emergency operations coordination
3. Medical surge

1.4 SITUATION

The IDPH ESF-8 Plan and its corresponding annexes are activated when the State Incident Response Center (SIRC) is activated and/or at the discretion of the IDPH director when circumstances dictate and the Public Health Emergency Operations Center (PHEOC) is activated. It can be partially or fully implemented in the context of a threat, in anticipation of a significant event, or in response to an incident. Scalable implementation allows for appropriate levels of coordination.

1.5 AUTHORITIES

1.5.1 Within Illinois, the overall authority for direction and control of the response to an emergency medical incident rests with the governor. Article V, Section 6, of the Illinois Constitution of 1970 and the Governor Succession Act (15 ILCS 5/1) identify the officers next in line of succession in the following order: the lieutenant governor; the elected attorney general; the elected secretary of state; the elected

comptroller; the elected treasurer; the president of the Senate; and the speaker of the House of Representatives. The governor is assisted in the exercise of direction and control activities by his/her staff and in the coordination of the activities by Illinois Emergency Management Agency (IEMA). The State Emergency Operation Center (SEOC) is the strategic direction and control point for Illinois response to an emergency medical incident (See Attachment 3).

1.5.2 IDPH is the lead agency for all public health and medical response operations in Illinois. IDPH is responsible for coordinating regional, state, and federal health and medical disaster response resources and assets to local operations.

1.5.3 All requests for health and medical assistance with the care of burn victims during emergency events will be routed through the State Incident Response Center (SIRC) and the IEMA as indicated in the Request for Medical Resources (RFMR) process in the IDPH ESF-8 Plan. The request will then be directed by the SIRC manager to the IDPH SIRC liaison. IDPH will determine the best resources from the health and medical standpoint to deploy in order to fulfill the request.

1.5.4 The overall authority for direction and control of IDPH's resources to respond to an emergency medical incident is the Department's director. The line of succession at IDPH extends from the director to the assistant director, forward to the appropriate deputy directors of the IDPH offices.

1.5.5 The overall authority for coordinating the resources of the disaster RHCC hospital(s) that respond to an emergency medical incident is the Emergency Medical Services (EMS) medical director or designee.

2.0 CONCEPT OF OPERATIONS

2.1 GENERAL

2.1.1 Throughout the response and recovery periods, the IDPH ESF-8 Plan: Burn Surge Annex will provide the framework to evaluate and analyze information regarding medical, and public health assistance requests for response; develop and update assessments of medical and public health status in the impact area; and provide contingency planning to meet anticipated demands as they relate to burn victims.

2.1.2 When an incident occurs that meets the definition of a Burn MCI (See Section 2.1.4), subject matter expertise through the State Burn Coordinating Center (SBCC) will be provided to advise and/or direct operations as it pertains to burn patient movement, care guidelines and resource allocation within the context of the Incident Command System structure. Burn subject matter experts throughout the state and surrounding border states will be utilized.

2.1.3 Incidents that could prompt the activation of the Burn Surge Annex include, but are not limited to:

1. Activation of the IDPH ESF-8 Plan.
2. Overwhelming influx or surge of burn patients that meets the definition of a Burn MCI outlined in section 2.1.4.
3. Inadequate burn hospital resources (e.g., inpatient monitored beds, ventilators).
4. Damage or threats to hospital(s) with burn capabilities.
5. Staffing limitations (e.g., qualified and trained staff to care for burn patients).

6. Activation of hospital(s) disaster plan when surge capacity for burn patients has been exceeded.
7. Requests from border state(s) to assist with a surge of burn patients

See the *Burn Surge Annex Activation Pathway* in Attachment 4.

2.1.4 The following are the definitions of a Burn MCI for Illinois:

1. Local: Any event in which local trauma/burn resources are overwhelmed with the number and/or severity of injuries (e.g., patients with ≥ 20% TBSA burn) that exceeds local capacity to provide effective care without initiating the Mass Casualty Burn Center Referral Criteria.
2. Regional: Any event in which regional trauma/burn resources are overwhelmed with the number and/or severity of injuries (e.g., patients with ≥ 20% TBSA burn) that exceeds regional capacity to provide effective care without initiating the Mass Casualty Burn Center Referral Criteria.
3. Statewide: Any event in which state trauma/burn resources are overwhelmed with the number and/or severity of injuries (e.g., patients with ≥ 20% TBSA burn) that exceeds state capacity to provide effective care without initiating the Mass Casualty Burn Center Referral Criteria.

2.1.5 Regardless of the pathway to activation of the annex, the health care entities involved with the incident function independently and may activate the necessary internal resources and policies to successfully respond to the needs of the burn patients (e.g., early or expedited inpatient discharge).

2.1.6 Within the IDPH ESF-8 Plan, multiple annexes exist that address the needs of specialty populations (e.g., pediatric and neonatal patients, burn patients). Depending on the scope of the disaster, multiple annexes or components of each may need to be activated simultaneously in order to thoroughly address the specific needs of the victims (e.g., pediatric burn patients). Efforts have been made to ensure consistency between all annexes that address the needs of specialty populations. It is the recommendation that the experts for the specialty populations involved in the MCI work together to address any conflicts that may occur.

2.2 NOTIFICATION

2.2.1 Upon the activation of the Burn Surge Annex, the *Burn Medical Incident Report Form* (See Attachment 5) will be utilized to communicate necessary information about the annex activation with all affected entities and those entities that may be called upon to assist during the incident. See Section 2.2.3 for a listing of possible stakeholders that should be notified during the activation of the Burn Surge Annex. This form may be sent and received via any available communication method (e.g., SIREN, e-mail, facsimile). When the *Burn Medical Incident Report Form* is utilized during an event, the communication method that will be utilized for stakeholders to reply will be indicated on the form in the "Reply/Action required" section.

2.2.2 Affected entities and those entities that may be called upon to assist during the incident must have the ability to communicate pertinent information internally and externally from their facility. Information should be shared in the preferred and most expected method (i.e., SIREN). However, depending on the type of incident, the typical alert and messaging systems may not be available and alternate

communication methods will be utilized to communicate. Some of the possible established methods for communication that can be used include:

1. Telephone (landline)
2. Telephone (cellular)
3. Facsimile
4. Radio systems (StarCom, HAM/Amateur, MERCI, telemetry)
5. E-mail
6. Electronic emergency management systems
7. SIREN
8. HAv-BED Tracking System in each state
9. WebEOC®
10. Social media
11. Comprehensive Emergency Management Program (CEMP) (for information sharing including access to documents and resources)

2.2.3 The *Burn Medical Incident Report Form* (See Attachment 5) should be utilized by all stakeholders to assist with ensuring consistent communication between stakeholders and to provide a mechanism to request burn patient transfer resources and identify availability of resources at a facility. For burn care equipment resource needs/requests, complete the HICS 213RR form and submit it through the RFMR Process as outlined in the IDPH ESF-8 Plan. Listed below are facilities/agencies/ entities that either play a role in caring for burn patients or may be part of the incident response and should be notified and receive ongoing communications from the time the Burn Surge Annex is activated until normal operations resume. The *Burn Communication Pathway* (Attachment 6) outlines which stakeholders will typically communicate and share information with each other when the annex is activated. This communication process is similar to daily communication processes and other types of disasters. The Burn Communication Pathway is different from the RFMR process, although there is some overlap. The following list is not inclusive, nor are entities listed in any priority order. Depending on the type of incident, additional stakeholders should be included in the information sharing process as needed and appropriate.

1. Hospitals
   a. Acute care hospitals
   b. Hospitals with burn capabilities
   c. Trauma centers
   d. Psychiatric hospitals
   e. Rehabilitation hospitals
2. Regional Hospital Coordinating Centers (RHCC)
3. County emergency management agencies
4. Local emergency medical services (EMS) agencies
5. Local health departments (LHD)
6. IDPH Regional Emergency Medical Services Coordinator (REMSC)
7. Illinois Department of Public Health (IDPH)
8. Illinois Emergency Management Agency (IEMA)
9. Professional medical organizations
   a. Illinois College of Emergency Physicians (ICEP)

b. Illinois State Medical Society (ISMS)
c. American Pharmaceutical Association (APA)
d. Illinois Pharmacists Association (IPA)
e. Illinois Emergency Nurses Association (ENA)

10. Illinois Critical Access Hospital Network
11. Collaborative Healthcare Urgency Group (CHUG)
12. Border state agencies (Refer to Section 2.3.4 for specific notification details)
    a. Great Lakes Healthcare Partnership Program (includes Illinois, Indiana, Michigan, Minnesota, Ohio and Wisconsin) through the Minnesota Department of Health, Office of Emergency Preparedness
    b. Iowa - Iowa Department of Public Health duty officer
    c. Kentucky - Duty officer in the Commonwealth Emergency Operation Center (See Attachment 6)
    d. Missouri – Missouri Department of Health and Senior Services' Emergency Response Center (MDHSS ERC) as Missouri ESF-8 Lead
        i. For incidents that occur in Illinois counties served by St Louis Medical Operations Center (SMOC) (specifically, Madison, Monroe and St Clair counties), the SMOC should secondarily be contacted (See Attachment 7).
    e. American Burn Association (ABA) Midwest Region (includes Illinois, Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota, and Wisconsin) through the University of Nebraska Medical Center Burn Unit.
13. Health care coalitions
14. Any alternate treatment sites, alternate care sites and/or temporary medical treatment stations established during the incident.

2.2.4 IDPH and the SBCC will need to be in frequent and regular contact during each operational period as defined by IDPH. *Appendix 9: IDPH and SBCC Communication Process* and *Appendix 10: IDPH and SBCC Communication Process Algorithm* outline the details of how and what information shall be shared between IDPH and the SBCC during each operational period.

IDPH will provide the SBCC with the following information:

1. General incident information as determined by the PHEOC Incident Commander
2. Follow up information on issues that required IDPH assistance

The SBCC will provide IDPH with the following information:

1. Number of available burn beds in the state
2. *Burn Patient Tracking Log* (Attachment 13) to identify: the number of burn patients that were transferred; what healthcare facility the patients were transferred to and from; and the number of burn patients that still need interfacility transfer coordination
3. Number of medical consultations provided by the SBCC
4. Issues requiring IDPH assistance.

2.2.5 To assist stakeholders with identifying the Illinois hospitals with burn capabilities and outlining contact information and specific capabilities of each of these burn

facilities, the *Illinois Burn Resource Directory* has been developed (See Attachment 11).

2.3. ORGANIZATION

2.3.1 Hospital Response Structure

1. During a large burn mass casualty incident, resources at hospitals with burn capabilities will quickly become exhausted. Therefore, developing a system that outlines how hospitals can assist with providing burn care is crucial to the response. Dividing the hospitals into categories based on their pre-event burn and trauma capabilities can assist with ensuring burn patients are treated at the best possible facility during the event. See Section 2.4: *Patient Care and Movement* for more information on this coordination of care.
2. When this annex is activated, hospitals within Illinois will fall into one of the following four categories to assist with the coordination of care during a burn mass casualty incident. See Section 3.2.6 for additional information on the following categorization:
   a. Hospitals with burn capabilities (includes both American Burn Association {ABA} and non-ABA verified burn centers)
   b. Level I trauma /non-burn hospitals
   c. Level II trauma /non-burn hospitals
   d. Non-trauma/non-burn hospitals

2.3.2 Regional Response Structure

Each region will respond as indicated within its regional ESF-8 plan.

2.3.3 State Response Structure

1. State emergency management officials will activate the SIRC to coordinate state and/or federal support to local jurisdictions. The PHEOC will be activated by IDPH. RFMR will be processed in accordance with the IDPH ESF-8 Plan.
2. Upon receiving requests for burn medical resources, the SIRC manager will notify the IDPH SIRC liaison. The IDPH SIRC liaison will notify the IDPH duty officer within the PHEOC, who will request the SBCC be activated.
3. During an activation of the PHEOC in the event of a large number of burn casualties, burn subject matter experts from the SBCC will be integrated into the incident command structure to allow for an appropriate, coordinated and timely response to the needs of burn patients.
4. When this annex is activated, the request for burn specific medical resources by a hospital, hospital or regionally based alternate care site (ACS), hospital or regionally based alternate treatment site (ATS). and/or state temporary medical treatment station (TMTS) will follow the same pathway as the request for other medical resources as outlined in the IDPH ESF-8 Plan. These burn care resources can include but are not limited to:
   a. Equipment, supplies and medications
   b. Medical consultation
   c. Placement of burn patients in hospitals with burn capabilities

5. The IDPH REMSC(s) will assist with the communication between IDPH and the RHCCs. The REMSC(s) should be involved in the situational awareness briefings throughout the event during which the SBCC will provide updates on interactions/ communication with hospitals and their medical consultation and transfer coordination requests. The REMSC should then relay this information to their RHCC to assure loop closure and awareness of the response activities within their region.
6. IDPH, in conjunction with support agencies, the SBCC and the Trauma Advisory Council (TAC) Burn Advisory Subcommittee, develops and maintains this annex and accompanying operational guidelines that govern response actions related to large scale events leading to significant number of burn victims. However, support agencies may develop and maintain their own operational guidelines for internal use, which must be compatible with and in support of this annex. This would include the SBCC. See Section 2.3.6 and 3.2.2 for more information on the SBCC. See Section 2.3.7 and 3.2.7 for more information on the TAC Burn Advisory Subcommittee.

2.3.4 Multi-State Response Structure

The incident may require accessing burn resources that exist outside the border of Illinois. The PHEOC, in collaboration with the SIRC, may consider requesting out-of-state resources through normal request patterns, methods indicated within this annex and the IDPH ESF-8 Plan, and/or interstate mutual aid agreements, including Emergency Medical Assistance Compact (EMAC). Border states will be contacted as indicated below to identify burn resource availability, send information about the event, and to assist with the coordination of transfers.

a. Great Lakes Healthcare Partnership Program (GLHPP)
   A consortium of jurisdictions, including Minnesota, Wisconsin, Illinois, city of Chicago, Indiana, Michigan and Ohio, located within Federal Emergency Management Agency (FEMA) Region V that can provide communication and resource assistance in the first 24-72 hours of a significant incident in the region when other resources are being activated through conventional channels. The GLHPP Regional Burn Surge Annex provides guidance for accessing burn resources and coordinating a regional burn response for states that are part of the GLHPP. To access GLHPP burn resources, call the Minnesota Department of Health, Office of Emergency Preparedness at XXX-XXX-XXXX and ask for the Great Lakes Healthcare Partnership Program (GLHPP). More information on this process can be found in the GLHPP Alerting/Communication Annex.
b. Iowa
   Iowa Department of Public Health duty officer will serve as the primary contact for Iowa at XXX-XXX-XXXX. Once contacted, the duty officer will serve as the single point of contact to identify burn resource availability (hospitals, transport and EMS) and assist with communication with Iowa hospitals with burn capabilities.

c. Kentucky
The on-call Kentucky Emergency Management (KYEM) duty officer in the Commonwealth Emergency Operations Center will serve as the primary contact for Kentucky at XXX-XXX-XXXX. Once contacted, the KYEM duty officer will notify the KYEM manager on call, one of the ESF-8 Public Health/Kentucky Health Association Partners and the Kentucky Board of EMS based on the requested needs to assist with patient placement and transportation (See Attachment 7).

d. Missouri
Missouri Department of Health and Senior Services' Emergency Response Center (MDHSS ERC) will serve as the primary contact for Missouri. Contact the ERC at XXX-XXX-XXXX and inform the duty officer of requested action. The duty officer will contact the appropriate personnel for response and coordination including contact with the St. Louis Medical Operations Center (SMOC) as appropriate, sending information to Missouri hospitals and assisting with coordination of burn resources and burn transport. However, it is recommended that during burn surge incidents impacting the Illinois counties of Madison, Monroe and St. Clair, Illinois also contact the SMOC as the secondary contact for Missouri, at the Central County Emergency 911 Communications Center at XXX-XXX-XXXX and request the SMOC duty officer be contacted (See Attachment 8).

e. ABA Midwest Region: University of Nebraska Medical Center Burn Unit will serve as the primary contact for the ABA Midwest Region to identify burn resource availability and assist with communication within the Region's states (Illinois, Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota, and Wisconsin). They can be contacted at XXX-XXX-XXXX.

2.3.5 Federal Response Structure

When response to a disaster or emergency incident exceeds the resources and capabilities of Illinois to manage, IEMA will notify officials at FEMA Region V of the governor's forthcoming request for federal assistance and a presidential disaster declaration. FEMA authorities will deploy a FEMA liaison officer to the SIRC when a presidential disaster declaration appears imminent.

2.3.6 State Burn Coordinating Center (SBCC)

1. Definition: The state of Illinois will establish one health care facility to act as the SBCC. This facility will be responsible for assisting IDPH through the PHEOC with managing any mass casualty burn incident as defined in this annex for which the resources of any given region or the state are overwhelmed. The SBCC should be a health care facility with recognized expertise in the care of burn patients, and the ability to accomplish the responsibilities outlined below, including providing consultative and care coordination assistance to hospitals beyond its geographic region, the state and to other states (as identified in the GLHPP Regional Burn Surge Annex).

2. Criteria for SBCC:
    a. Around-the-clock on-call coverage by a burn surgeon and burn disaster response support team
    b. Adult and pediatric trauma capabilities
    c. Telemedicine capabilities
    d. Redundant and diverse interoperable communications
    e. State Health Alert Network participation
    f. In addition, the SBCC is encouraged to seek other opportunities that would lend to enhancing their expertise and excellence in burn and trauma care, such as standards defined by national professional organizations (e.g., American Burn Association verification as a Burn Center or the American College of Surgeon Trauma Center Designation).
3. Redundancy Plan: IDPH PHEOC will assist with identifying a secondary/ back up SBCC should the pre-designated SBCC be unable to fill this role. Hospitals with burn capabilities should preplan to have internal plans, processes and systems in place to fill this role as needed during a large scale event. Appendix 9 and 10 outline the process to either partially or fully transfer the role of SBCC from the pre-designated SBCC to another hospital with burn capabilities.

2.3.7 Trauma Advisory Council (TAC), Burn Advisory Subcommittee

Purpose

a. Coordinate and provide oversight to ongoing efforts associated with assuring preparedness for a large-scale burn incident.
b. Assure longevity by incorporating burn surge planning into an already existent state infrastructure.
c. Allow key stakeholders from throughout the state to be involved in the decision-making for future planning and coordination for burn surge events, and other burn related issues.
d. Assist with multiple long-term maintenance activities associated with statewide burn planning (e.g., ongoing training/education and exercises; review of burn management protocols, supply cache guidelines and the Burn Surge Annex).

2.4. PATIENT CARE AND MOVEMENT

The Burn Surge Annex is designed to help coordinate the following components of care as related to burn victims during an incident.

2.4.1. Patient Tracking

As burn patient movement occurs throughout Illinois and its border states, tracking the location of patients is crucial in aiding the reunification with their families, especially for pediatric burn patients. Electronic patient tracking may be available (e.g. EMTrack). Manual tracking of patient movement through the methods listed below will be necessary if the electronic system is unavailable or can be used in conjunction with the electronic systems.

1. *Patient Identification Tracking Form* (See Attachment 12)
   a. Purpose: To assist in identifying, tracking and reunification of burn patients during and after a disaster.
   b. Responsibility: The primary physician and/or nurse at every health care facility.
   c. Instructions: This form will be completed to the best of the ability given the information/resources available on ALL burn patients that arrive at a health care treatment facility (hospital, clinic, ACS, ATS and TMTS) regardless if they are accompanied by a family member or, if the patient is a child, accompanied by their parent/guardian. This form records patient tracking number (assigned by initial health care facility), demographic information, description of the patient, a place to attach a photo of the patient, patient tracking log, accompanied and unaccompanied child information, medical history and disposition. The form should be copied. The original of this form will accompany the patient if/when the patient is transferred to another facility and a copy should be kept as part of the facility's medical record. Each receiving facility will add their facility's information in the Patient Tracking Log section. **NOTE: Attempts should be made to keep patient identification (ID) bands from previous facilities and triage tags from EMS on the patient.** If ID bands need to be removed, attach the removed band to this form under the Patient Tracking Log section of this form. If triage tags are removed, ensure all information on the tag is incorporated into the patient's medical record or, if possible, place a photo copy of the tag in the patient's medical record. This form would be used in conjunction with available electronic tracking systems.
2. *Burn Patient Tracking Log* (See Attachment 13)
   a. Purpose: To assist with tracking burn patients during a disaster.
   b. Responsibility: Burn subject matter experts at the SBCC who are assisting with the coordination of patient movement.
   c. Instructions: This form will be completed as the transfer of burn patients is coordinated by the SBCC and patients are transported to other health care facilities. Any issued tracking number (assigned by initial health care facility), name, gender or date of birth, hospital's name, location and time transfer was completed shall be recorded on all patients. This document will be forwarded to IDPH at the PHEOC at the end of each operational period by the SBCC and stored in the same manner as other incident-related command documents after the PHEOC closes.
3. Additional Burn Patient Tracking Resources: American Red Cross (ARC) Patient Connection Program

   The Patient Connection Program may be available during a large scale event throughout Illinois and northwest Indiana. The program is activated when a local incident sends 10 or more people to hospitals. A call center is opened for inquiries about those who may have been hospitalized. Hospitals should follow the procedure outlined in the memorandum of understanding (MOU) with the ARC.

2.4.2. Patient Triaging and Transfer Coordination

During burn MCIs, resources at hospitals with burn capabilities will quickly become exhausted. Therefore, hospitals may need to care for burn patients for longer periods of time until they are able to transfer these patients to a higher level of care. The *Hospital Burn Triage Guidelines* (Attachment 15) were developed to ensure burn patients are triaged to hospitals that, based on their pre-event capabilities (through designation within the Illinois Trauma System), are most appropriate to provide burn care until that patient can be transferred or referred to a hospital with burn capabilities. Specifically within the *Hospital Burn Triage Guidelines* are Mass Casualty Burn Center Referral Criteria that is intended to assist with triage decisions primarily for hospital-to-hospital transfers, not triage at the scene. The *Burn Medical Incident Report Form* (See Attachment 5) should be utilized to provide requests for burn resources and to communicate the number and triage category for patients needing interfacility transfer.

1. *EMS Burn Triage Guidelines (See Attachment 14)*
2. *Hospital Burn Triage Guidelines* (See Attachment 15)
    a. Purpose: To provide EMS, SBCC and hospitals (regardless of their burn capabilities) guidance on determining patients that should be triaged to hospitals with burn capabilities during a burn mass casualty incident.
    b. Responsibility: EMS agencies and hospitals regardless of their burn capabilities are recommended to be familiar with and utilize the *Burn Triage Guidelines* to assist with transfer decision-making during a burn MCI. The SBCC also will utilize these guidelines to assist in the transfer coordination of burn patients during a burn MCI.
    c. Instructions: As outlined in the *EMS Burn Triage Guidelines (Attachment 14),* EMS would follow their system protocols for response to a MCI and triage using state approved MCI triage methods (START/ JumpSTART©) and coordinate with local medical control to divide the patients based on their needs and resources available. It is also important that EMS consider assisting with patient tracking/family reunification per their protocols and the recommendations within the *EMS Burn Triage Guidelines*. Once patients arrive at the initial hospital for treatment, the *Hospital Burn Triage Guidelines (Attachment 15),* including the Mass Casualty Burn Center Referral Criteria, should be initiated. These tools and guidance from the SBCC, should help guide practitioners in determining the most appropriate category of hospital for a burn patient to be transferred to in order to receive burn care during a burn MCI (See Section 2.3.1 and 3.2.6 for hospital category definitions). The initial hospital should complete the "Current Number of Burn Patient Placement Needs" section of the *Burn Medical Incident Report Form* (Attachment 5) to communicate the number and types of burn patients that need to be transferred to a different facility for care. On page 1 of this form, the total number of patients for each triage category should be identified. On page 2 of this form, the following information should be included: patient tracking number, triage category, age and

gender. No additional patient injury or care information should be included on this form. This form should then be sent to the SBCC via the mechanism identified in the "Reply/Action Required" section.

3. Upon receiving the *Burn Medical Incident Report Form* from non-burn hospitals, the SBCC will identify bed placement based on the triage categories identified for each patient. The SBCC should consider using existing bed reporting systems, and direct communication with hospitals. *Attachment 16: Distributing Burn Patients to Trauma/Non-Burn Hospitals* may assist with identifying the most appropriate hospital to accept the patient by identifying the different capabilities between a Level I and Level II Trauma Center in Illinois as well as providing a list of all Level I and Level II Trauma Centers in the Illinois Trauma System. Once a receiving hospital has been identified, the SBCC will send the information to the transferring hospital via the Burn Medical Incident Report Form, ensuring that the patient tracking number is listed with the receiving hospital information.
4. *Burn Patient Transfer Form* (See Attachment 17)
    a. Purpose: To provide a method of communicating medical and treatment information on burn patients during a disaster when the patients are being transferred to another facility for care. This information will be shared with the physician at the receiving facility and assist with ensuring continuity of care for burn patients when they arrive at the receiving facility. This form may also be used by the SBCC to assist with triage decision making for patients who may need special consideration during the triage process.
    b. Responsibility: The physician responsible for the burn patient at the transferring hospital and who has identified a higher level of care is needed than what can be provided at the transferring health care facility.
    c. Instructions: This form will be completed at the transferring health care facility and sent with the patient to the receiving hospital. This form provides the providers at the receiving hospital with patient tracking number (assigned by initial health care facility), basic demographic information, past medical history, burn injury history, medical management that has been performed prior to transfer, and transport needs.

2.4.3. Patient Transport

The transportation needs during a large scale incident leading to significant numbers of burn patients may be quite extensive. The referral physician and staff, the SBCC and accepting/receiving physician will work together to identify the resources needed to transport the burn patient(s) in the most efficient and safe manner available at the time. The SBCC may be able to assist hospitals in identifying transport resources and alternative methods for transporting burn patients, especially if interstate transport is required. If transport resource assistance is needed, the sending hospital should follow the RFMR process and request assistance from their RHCC. The Illinois Association of Air and Critical Care Transport maintain an *Illinois Aircraft Resource Guide* and an *Illinois*

Critical Care Ground Resource Guide that may assist with identifying transport resources throughout the state during a disaster. This list which may not be inclusive, can be found at: http://iaacct.org/resources/.

2.4.4. Burn Guidelines

During a large scale incident, normal interfacility transfer patterns may be disrupted. Hospitals that typically transfer acutely ill/injured burn patients to hospitals with burn capabilities may need to care for these patients for longer periods of time until they are able to transfer these patients to a higher level of care. The SBCC can be accessed for medical consultation. In addition, the *Adult Burn Guidelines* (See Attachment 18) and the *Pediatric Burn Guidelines* (See Attachment 19) are available as an adjunct to this annex. These documents provide support and guidance to those practitioners caring for burn patients during the initial 72 hours following an incident.

1. Purpose: To provide guidance to practitioners caring for adult and pediatric burn patients during a disaster.
2. Responsibility: These guidelines are not meant to be all inclusive, replace an existing policy and procedure at a hospital or substitute for clinical judgment. These guidelines may be modified at the discretion of the health care provider.
3. Instructions*:* Practitioners may use these guidelines as a reference and to assist with care of burn patients during a disaster. The guidelines will be updated and maintained by the Illinois TAC Burn Advisory Subcommittee.

2.4.5. Ongoing burn education

To assist non-burn hospitals with caring for burn patients during a burn MCI, the *Illinois Disaster Training Course: Management of Burn Patients at Non-Burn Hospitals* has been developed. This course shall be offered to non-burn hospital healthcare professionals to provide the education and training needed to admit and care for burn patients for extended periods of time during a burn MCI.

2.4.6. Burn Supply Caches

During burn MCIs, resources at hospitals with burn capabilities will quickly become exhausted. Hospitals, regardless of their burn capabilities, should consider incorporating burn supplies into their internal disaster supply caches and adjust the volume within the cache based on their surge planning. The *Recommended Burn Supply Cache* was developed to assist with this burn surge supply planning (See Attachment 20). Hospitals without burn capabilities may consider building their burn supply cache to care for minimally five burn patients. Non-burn trauma centers that may care for more significantly ill/injured burn patients, may consider building burn supply cache to care for minimally 10 burn patients. The *Recommended Burn Supply Cache* list will be maintained and updated by the Illinois TAC Burn Advisory Subcommittee. Regional and statewide burn supply caches also may be available during a burn MCI. The request for these resources should follow the RFMR process as outlined in the IDPH ESF-8 Plan.

3.0 ROLES, RESPONSIBILITIES, AND RESOURCE REQUIREMENTS

3.1 PRIMARY AGENCY

3.1.1 ILLINOIS DEPARTMENT OF PUBLIC HEALTH

1. Provide leadership in directing, coordinating and integrating overall state efforts to provide public health and medical assistance to affected areas and the populations within those areas.
2. Assist with the communication between stakeholders (e.g., hospitals, LHDs, border states, GLHPP) during an incident.
3. Coordinate and direct the activation and deployment of this Burn Surge Annex as part of the IDPH ESF-8 Plan either partially or in its entirety as indicated by the burn resource needs following an incident.
4. Collaborate with IEMA on the RFMRs for burn specific resources from hospitals, public health departments, alternate care sites, alternate treatment sites and temporary medical treatment stations.

3.2 SUPPORT AGENCIES/FACILITIES/ORGANIZATIONS

3.2.1 ILLINOIS EMERGENCY MANAGEMENT AGENCY

1. Work with specific agency(ies) within jurisdiction(s) to gain a situational awareness of the incident.
2. Collaborate with IDPH on the RFMRs for burn specific resources from hospitals, LHDs, alternate care sites, alternate treatment sites and temporary medical treatment stations.
3. Proceed with established procedures for requesting disaster declaration (state and federal) as indicated.
4. Proceed with established procedures for facilitating EMAC requests as indicated.

3.2.2 STATE BURN COORDINATING CENTER (SBCC)

1. Pre-event
    a. Designate a chair for the TAC Burn Advisory Subcommittee.
    b. Participate in the TAC Burn Advisory Subcommittee and assist with projects related to state burn surge planning (e.g., ongoing training/education and exercises; ongoing review of burn management protocols, supply cache guidelines and the State Burn Surge Annex).
    c. Ensure mechanisms are in place internally to respond as the SBCC during an event (e.g., internal burn surge plan, incorporation of SBCC roles into Incident Command Structure, redundant and diverse communication systems). See Attachment 21 for *SBCC HICS Organizational Chart* and Attachment 22 for *SBCC Job Action Sheets*.
    d. Ensure contingency plan is in place if unable to fulfill SBCC role during a burn mass casualty incident.
    e. Identify single point of contact within *Illinois Burn Resource Directory* (Attachment 11).
    f. Collaborate with the other hospitals with burn capabilities to coordinate and host yearly burn education throughout the state for non-burn hospitals including Advanced Burn Life Support (ABLS) and the Illinois

Burn Disaster Training Course: Management of Burn Patients at Non-Burn Hospitals

2. During an event
    a. Verify single point of contact.
    b. Coordinate burn consultation to those non-burn hospitals (i.e., trauma centers with no burn capabilities and non-trauma/non-burn hospitals).
    c. Utilize telemedicine as appropriate and available.
    d. Assist IDPH with statewide triage and the coordination of interfacility transfers of burn patients from non-burn facilities to burn facilities.
    e. Assist IDPH with the coordination of patient placement (either intra state or interstate).
    f. Communicate with key stakeholders (IDPH, GLHPPP and additional border states) (See Appendix 9 and 10 for additional information
    g. Ensure proper documentation.
        i. *Burn Patient Tracking Log* (Attachment 13):
        The purpose of the Burn Patient Tracking Log is to assist with tracking burn patients during a burn MCI. This document should be completed and maintained by the SBCC for all patients that the SBCC assists with transfer coordination between two health care facilities. This form will be used as a reference for the SBCC and IDPH to assist with reunification of patients and their families. At the end of each operational period (or other agreed upon designated time frame between IDPH and the SBCC), the SBCC will forward this completed form to IDPH IMT at the PHEOC who will store it in the same manner as other incident related command documents.
        ii. *Burn Casualty Communication Log* (Attachment 23)
        The purpose of the Burn Casualty Communication Log is to provide a standardized method of tracking communication between health care facilities and the SBCC during a burn MCI. A designated SME at the SBCC will complete this form on each contact it has with other health care facilities (e.g. transfer coordination requests, medical consultation or other burn resource needs). This form should be stored by the SBCC in the same manner as other incident related command documents.
        iii. *Post-Event Data Collection Log* (Attachment 24)
        The purpose of the *Post-Event Data Collection Log* is to assist with compiling data after a burn MCI that can provide lessons learned and improvements to response plans and the Burn Surge Annex. A designated SME at the SBCC will complete this form on all patients that the SBCC assists with transfer coordination between two health care facilities or provides medical consultation to. This form will be used to evaluate the disposition and outcomes of burn patients when the annex is activated during a burn MCI. Information on this form should then be shared with the Trauma Advisory Council, Burn Advisory Subcommittee in order to thoroughly evaluate the patient care processes within the annex and address any gaps. The SBCC

will store it in the same manner as other incident related command documents.

3. Post-event
    a. Conduct an internal debriefing and after action report (AAR) and participate in the IDPH debriefing and contribute to the IDPH AAR.
    b. Provide lessons learned to the TAC Burn Advisory Subcommittee, IDPH, GLHPP and other border states as appropriate.
    c. Provide lessons learned to key stakeholders (e.g., resource hospitals, RHCCs, EMS) to identify improvement opportunities at the local level.
    d. Assist the TAC Burn Advisory Subcommittee with outlining recommendations to IDPH for updating the Burn Surge Annex based on lessons learned from the event.

3.2.3 REGIONAL HOSPITAL COORDINATING CENTER (RHCC)

1. Provide care for burn patients who arrive at the facility to the best of the facility and practitioners' ability.
2. Provide patient families at their facility with information about the event and education about components of the response that may involve their family member's care (e.g., coordination of care statewide and transfer processes).
3. Provide necessary situational awareness communications to/from the affected and/or assisting hospital(s) within the region and to/from IDPH.
4. Inform IDPH, as appropriate, when regional ESF-8 Plan has been activated.
5. Inform IDPH, as appropriate, when regional burn resources have been depleted.
6. Assist with the communication and RFMR for burn specific resources as indicated in this annex (See Attachment 6 for *Burn Communication Pathway* and Section 2.2.3).
7. Assist hospitals with accessing Illinois Helps. (See Section 3.2.10)
8. Function as a liaison between IDPH, IEMA, and hospitals and EMS providers within its region.
9. See Section 3.2.6 for additional roles and responsibilities based on pre-designated burn capabilities.

3.2.4 RESOURCE HOSPITALS

1. Provide care for burn patients who arrive at the facility to the best of the facility and practitioners' ability.
2. Provide patient families at their facility with information about the event and education about components of the response that may involve their family member's care (e.g., coordination of care statewide and transfer processes).
3. Assist with the communication and RFMRs for burn specific resources as indicated in the regional ESF-8 Plan, the IDPH ESF-8 Plan and in this annex (See Attachment 6 for *Burn Communication Pathway* and Section 2.2.3).
4. Function as a liaison between the EMS associate and participating hospitals within their system and the RHCC.
5. Assist with the communication with EMS providers within their EMS system.
6. See Section 3.2.6 for additional roles and responsibilities based on pre-designated burn capabilities.

3.2.5 ALL OTHER HOSPITALS

1. Provide care for burn patients who arrive at the facility to the best of the facility and practitioners' ability.
2. Provide patient families at their facility with information about the event and education about components of the response that may involve their family member's care (e.g., coordination of care statewide and transfer processes).
3. Communicate and submit RFMR for burn resources as necessary as indicated in the regional ESF-8 Plan, the IDPH ESF-8 Plan and in this annex (See Attachment 6 for *Burn Communication Pathway* and Section 2.2.3).
4. See Section 3.2.6 for additional roles and responsibilities based on pre-designated burn capabilities.

3.2.6 ADDITIONAL HOSPITAL BURN CATEGORIZATION

The following information provides the definitions of the categorization of hospitals as it relates to this annex and the response during a burn MCI. The roles and responsibilities outlined below are *in addition* to the roles and responsibilities outlined in Sections 3.2.3, 3.2.4 and 3.2.5.

1. HOSPITALS WITH BURN CAPABILITIES
   a. Pre-event
      i. Participate in the TAC Burn Advisory Subcommittee and assist with projects related to state burn surge planning (e.g., ongoing training/education and exercises; ongoing review of burn management protocols, supply cache guidelines and the State Burn Surge Annex)
      ii. Ensure mechanisms are in place internally to respond as a backup SBCC during an event, if the pre-identified SBCC is unable to fulfill its role (e.g., internal burn surge plan, incorporation of SBCC roles into Incident Command Structure, redundant and diverse communication systems). See Attachment 21 for *SBCC HICS Organizational Chart* and Attachment 22 for the *SBCC Job Action Sheets*.
      iii. Identify single point of contact.
      iv. Collaborate with the SBCC to coordinate and host yearly burn education throughout the state for non-burn hospitals including Advanced Burn Life Support (ABLS) and the Illinois Burn Disaster Training Course: Management of Burn Patients at Non-Burn Hospitals
   b. During an event
      i. Verify single point of contact.
      ii. Coordinate with the SBCC to accept and to care for those patients triaged as Category 1 and who meet the Mass Casualty Burn Center Referral Criteria (See Attachment 15 for *Hospital Burn Triage Guidelines* and the Mass Casualty Burn Center Referral Criteria).
      iii. Prepare and accept functioning as the SBCC if requested due to the predesignated SBCC being unable to function in this role.
   c. Post event

      Assist the TAC Burn Advisory Subcommittee with outlining recommendations to IDPH for updating the Burn Surge Annex based on lessons learned from an event or exercises.

2. LEVEL I and LEVEL II TRAUMA/NON-BURN HOSPITALS
   a. Pre-event
      Provide feedback to the TAC Burn Advisory Subcommittee on projects related to state burn surge planning (e.g., ongoing training/education and exercises; ongoing review of burn management protocols, supply cache guidelines and the State Burn Surge Annex).
   b. During an event
      i. Coordinate with the SBCC during the event to accept and care for those patients triaged as Category 2 and Category 3 (See Attachment 15 for *Hospital Burn Triage Guidelines* and the Mass Casualty Burn Center Referral Criteria).
      ii. Coordinate with the SBCC through the processes outlined in the annex to triage and transfer burn patients to higher level of care.
3. NON-BURN/NON-TRAUMA HOSPITALS
   During an event
      i. Coordinate with SBCC during the event to accept and care for those patients triaged as Category 3, 4 and 5 (as appropriate based on hospital's capabilities) (See Attachment 15 for *Hospital Burn Triage Guidelines* and the Mass Casualty Burn Center Referral Criteria).
      ii. Coordinate with the SBCC through the processes outlined in the annex to triage and transfer burn patients to higher level of care.

3.2.7 TRAUMA ADVISORY COUNCIL (TAC) BURN ADVISORY SUBCOMMITTEE

Coordinate and provide oversight to ongoing efforts associated with ensuring preparedness for a large-scale burn incident in Illinois. Incorporating burn surge planning into an already existent state infrastructure will ensure longevity of burn preparedness activities. A burn expert from the SBCC will chair the subcommittee, and an Illinois TAC member will serve as co-chair. The Burn Advisory Subcommittee's roles and responsibilities occur during the planning and preparedness/mitigation phases, and do not have a direct role in the response.

1. Function under the direction of the TAC and follow the hierarchy and reporting structure outlined in the TAC bylaws and the Burn Advisory Subcommittee bylaws.
2. Establish relationships and partnerships with key stakeholders and coordinate with these stakeholders from throughout the state to be involved in the decision-making related to future planning and coordination for burn surge events, and other burn related issues.
3. Assist with the multiple long-term maintenance activities associated with statewide burn planning (e.g., ongoing training/education and exercises; ongoing review of burn management protocols, supply cache guidelines and the State Burn Surge Annex) to ensure a consistent approach across the state.

3.2.8 LOCAL HEALTH DEPARTMENTS

1. Assist hospitals in obtaining supplies from the Strategic National Stockpile (SNS), specific to burn patients, as requested, through the processes that are currently identified and incorporated into their existing plans and the RFMR process outlined in the IDPH ESF-8 Plan.

2. Maintain communication and provide situational awareness updates, specific to burn patients, to hospitals and IDPH as indicated.

3.2.9 BORDER STATES

1. Great Lakes Healthcare Partnership Program (GLHPP)
   a. The IDPH representative or the representative from the SBCC will notify the Minnesota Department of Health, Office of Emergency Preparedness at XXX-XXX-XXXX and specifically ask for the GLHPP contact who can assist with the communication and resource assistance in the first 24-72 hours of a significant incident involving a large number of burn casualties.
   b. The GLHPP Regional Burn Annex has been developed for the members of the GLHPP to expand the ability to provide burn care, and to safeguard and to prioritize the utilization of limited resources.
   c. Each state identifies a SBCC to facilitate a uniform response to a mass burn incident that exceeds the resources available at the local, regional, city, or state level and can assist with the coordination of care with other GLHPP SBCCs.
2. Iowa
   The IDPH representative or the representative from the SBCC will notify the on call Iowa Department of Public Health duty officer at XXX-XXX-XXXX regarding the situation and burn resource needs. The duty officer can then assist with the identification of burn resource availability in hospitals, transport services and EMS, and assist with communication with Iowa hospitals/agencies.
3. Kentucky
   The IDPH representative or the representative from the SBCC will notify the on call KYEM duty officer in the Commonwealth Emergency Operations Center at XXX-XXX-XXXX regarding the situation and burn resource needs. The KYEM duty officer can assist with the identification and coordination of available burn resources (i.e., hospital and transport) (See Attachment 7).
4. Missouri
   Missouri Department of Health and Senior Services' Emergency Response Center (MDHSS ERC) will serve as the primary contact for Missouri. Contact their ERC at XXX-XXX-XXXX and inform the duty officer of requested action. The duty officer will contact the appropriate personnel for response and coordination including contact with the St. Louis Medical Operations Center (SMOC) as appropriate, sending information to Missouri hospitals and assisting with coordination of burn resources and burn transport. However, it is recommended that during burn surge incidents impacting the Illinois counties of Madison, Monroe and St. Clair, Illinois also contact the SMOC as the secondary contact for Missouri, at the Central County Emergency 911 Communications Center at XXX-XXX-XXXX and request the SMOC duty officer be contacted (See Attachment 8).
5. American Burn Association (ABA) Midwest Region
   The ABA Midwest Region includes Illinois, Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota, and Wisconsin. The University of Nebraska Medical Center Burn Unit has been designated as the Regional Coordinating Center and may be able to offer additional assistance

with sending information to the burn hospitals in its region and assist with coordination of burn resources and burn patient placement in these states. The contact phone number for burn unit at the University of Nebraska Medical Center is XXX-XXX-XXXX.

3.2.10 ILLINOIS HELPS

The Emergency System for Advanced Registration of Volunteer Health Professionals (ESAR-VHP) system for Illinois (Illinois HELPS) supports the pre-registration, management, and mobilization of clinical and non-clinical volunteers to help in responding to all types of disasters. The volunteer management system is part of a nationwide effort to ensure volunteer professionals can be quickly identified and their credentials checked so they can be properly utilized in a disaster response.

a. Role and Responsibility:
   Provide a method to track credentials, qualifications, certifications, contact information and training of burn experts throughout the state.

IDPH ESF-8 Plan: Burn Surge Annex: 2016
Attachment 1: Overview of Burn Surge Annex
November 2016

EMS responds and identifies MCI with large number of burn victims
EMS follows MCI protocols:

- Notifies resource hospital of estimated number of casualties
- Begins MCI triage
- Distributes patients to multiple hospitals based on protocols and guidance from resource hospital

Once resource hospital receives call, follows protocol to identify hospitals for EMS to transport patients to.

Depending on where the incident occurs and the available burn resources at the local or regional level, as burn resources are exhausted, hospitals identify the need to request burn resources.

NOTE: Hospitals may specifically request the Burn Surge Annex be activated; or as IDPH receives multiple requests for burn resources, this should prompt the activation of the Annex

NOTE: Resource requests should follow the RFMR process outlined in the IDPH ESF-8 Plan

IDPH determines the need to activate the Annex based on burn resource requests

IDPH follows the IDPH and SBCC Communication Process (Attachment 9) to notify and activate LUMC as the SBCC.

SBCC opens its EOC and activates internal processes to function in the role of SBCC. Once ready, SBCC notifies IDPH.

IDPH sends a notification to all hospitals and other stakeholders about the following:

- The incident
- Activation of the Annex
- Activation of the Burn Triage Guidelines
- Activation of the SBCC
- Process to contact SBCC for medical consultation and transfer coordination
- Additional actions needed at the time

NOTE: Attachment 5: Burn Medical Incident Report Form is the primary method of communication when the Annex is activated and ongoing communication. It will be sent out by whatever method is available (e.g. SIREN, email, fax, etc.)

SEE PAGE 2 FOR ROLES, RESPONSIBILITIES AND ACTIONS FOR IDPH, SBCC, BURN HOSPITALS and NON-BURN HOSPITALS ONCE ANNEX IS ACTIVATED

ROLES, RESPONSIBILITIES AND ACTIONS FOR IDPH, SBCC, BURN HOSPITALS and NON-BURN HOSPITALS ONCE ANNEX IS ACTIVATED

Incident occurs; Burn Surge Annex is activated

IDPH

- Lead agency when Annex is activated
- Assist with burn medical resource requests (supplies)
- Communicate with SBCC

HOSPITALS

State Burn Coordinating Center

- Activate EOC and internal plans to fulfill the role of SBCC
- Communicate with IDPH as outlined in *Attachment 9: IDPH and SBCC Communication Process*
- Communicate with all other stakeholders as outlined in the Annex. See *Attachment 6: Burn Communication Pathway*.
- Utilize *Attachment 15: Hospital Burn Triage Guidelines* and *Attachment 16: Distributing Burn Patients to Trauma/Non-Burn Hospitals* to identify the most appropriate hospital to care for burn patients as hospitals submit transfer requests.
- Complete and maintain *Attachment 13: Burn Patient Tracking Log* on all patients in which a transfer was coordinated.
- Complete *Attachment 23: Burn Patient Casualty Communication Log* for each contact with other health care facilities
- Provide medical consultation to non-burn hospitals as requested
- After the incident has resolved, complete *Attachment 24: Post Event Data Collection Log* to evaluate the disposition and outcomes of burn patients while the Annex was activated

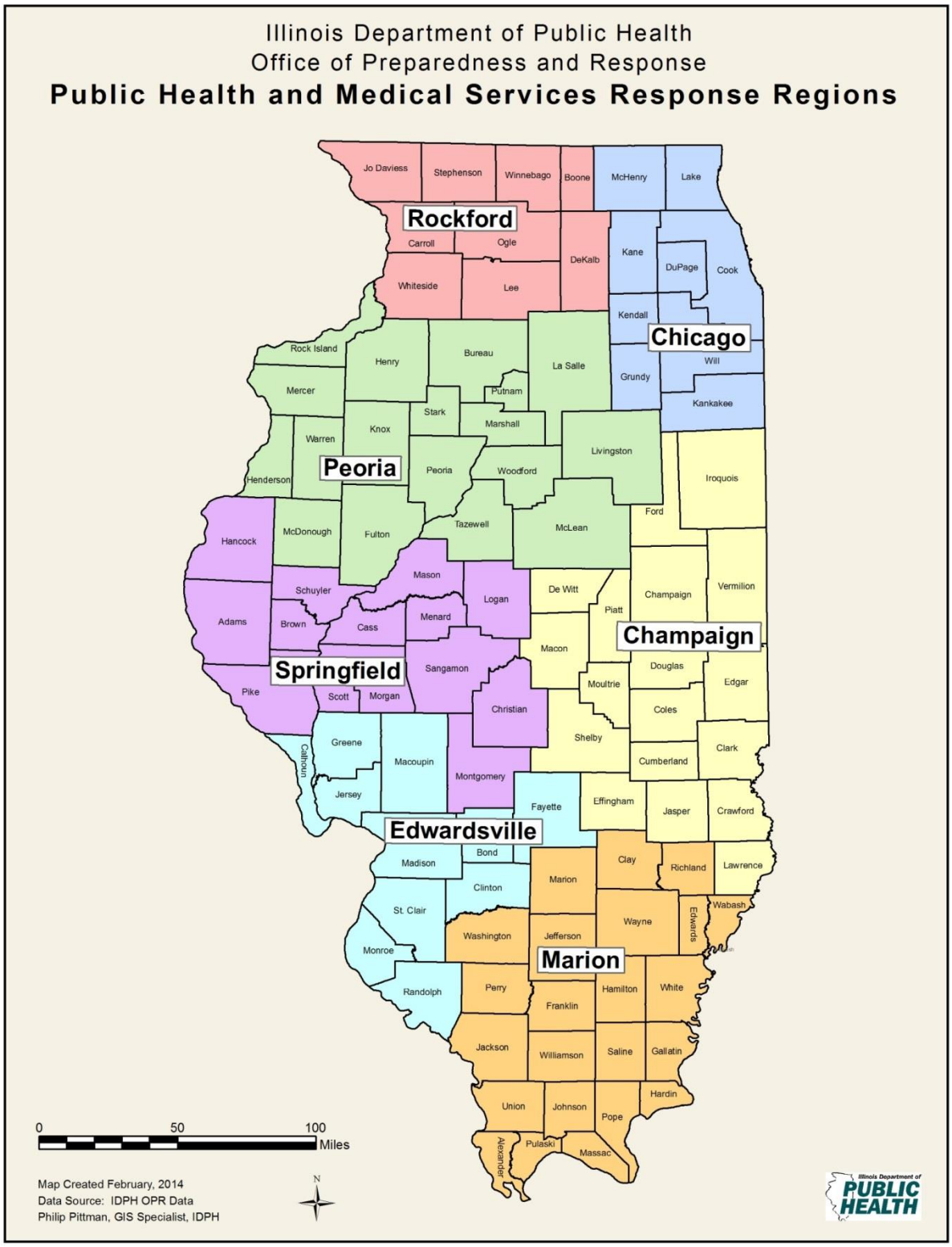
Burn Hospitals

- Provide medical/burn care to patients as they arrive at the hospital
- Activate internal burn surge plans
- Decompress burn units
- Collaborate with SBCC to accept Category 1 transfers from non-burn hospitals
  - Care for Category 1 burn patients once they arrive from non-burn hospitals
- If requested, activate internal processes to function as the secondary SBCC should LUMC be unable to serve in this role

Non-Burn Hospitals

- Care for patients as they arrive at their hospital and use available patient burn care resources to assist:
  - *Attachment 18: Adult Burn Care Guidelines*
  - *Attachment 19: Pediatric Burn Care Guidelines*
  - Contact the SBCC for remote medical consultation/guidance
- Utilize *Attachment 15: Hospital Burn Triage Guidelines* to triage patients at their hospital that need to be transferred to another facility
- Request transfer coordination assistance by completing the *Attachment 5: Burn Medical Incident Report Form* and submitting it to the SBCC. Once received by the SBCC and a receiving hospital is identified, this form will be sent back to the local hospital with transfer information
- Once receiving hospital is identified:
  - Complete *Attachment 17: Burn Patient Transfer Form. S*end this form with patient when transported to the receiving hospital
  - Complete A*ttachment 12: Patient Identification Tracking Form*. Send this form with patient when transported to receiving hospital
  - Coordinate available and most appropriate transport resources to move the patient from the transferring hospital to receiving hospital
- Admit and care for burn patients based on the Mass Casualty Burn Center Referral Criteria within *Attachment 15: Hospital Burn Triage Guidelines* if unable to transfer to a burn hospital..
  - Level I and Level II Trauma Centers
  - Hospitals with ICU capabilities

ATTACHMENT 2: PUBLIC HEALTH AND MEDICAL SERVICE RESPONSE REGIONS MAP



ATTACHMENT 3: IDPH OPR IMT ORGANIZATIONAL CHART

Chart of IDPH Office of Preparedness and Response Incident Management Team (IMT)

Command Staff

Incident Commander
Title
OPR Deputy
EMS Chief
FGM Chief

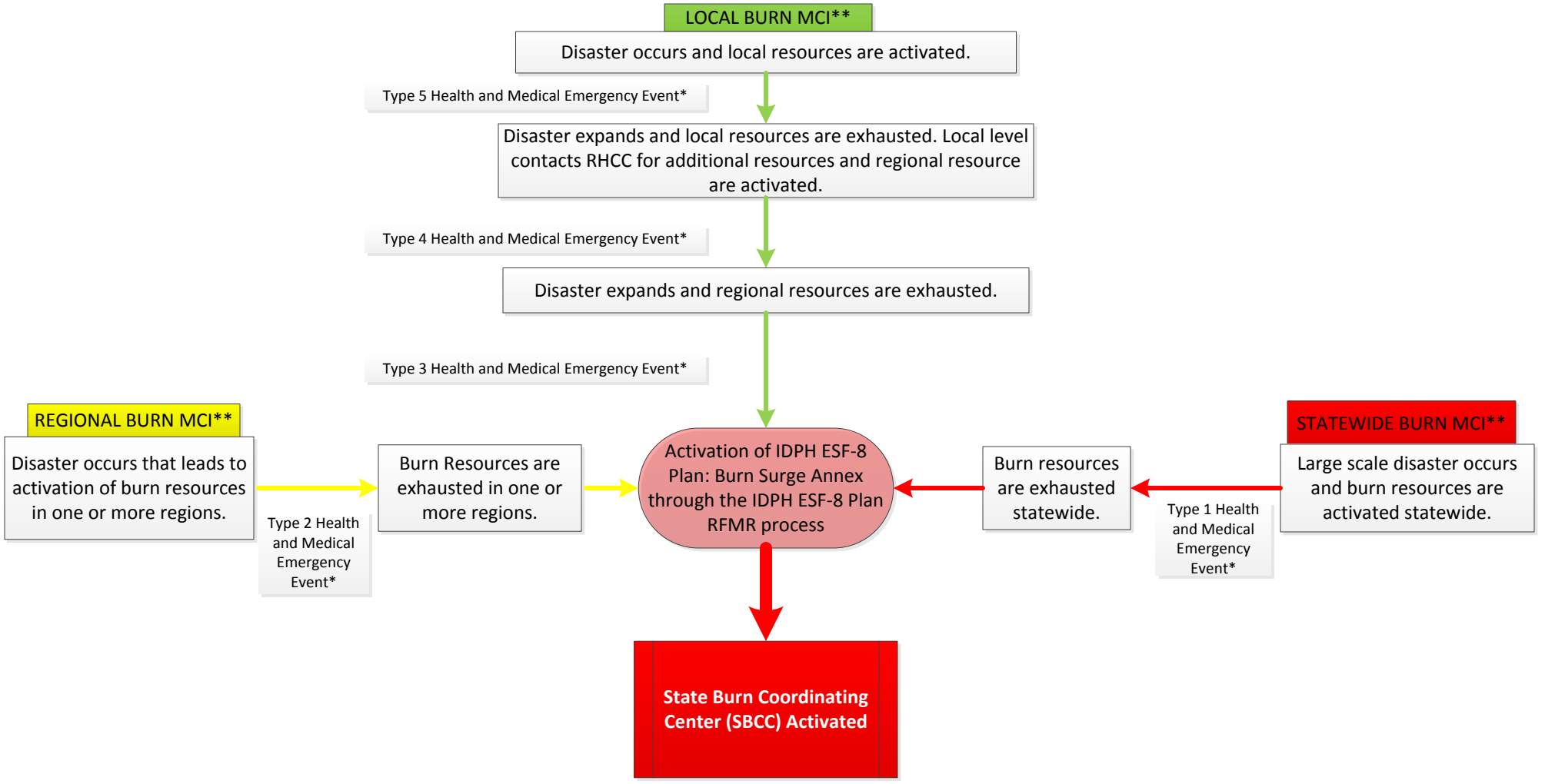
Safety Officer	Liaison Officer	Public Information Officer	State ESF-8 Lead State Incident Response Center (SIRC)
Title	Title	Title	Title
T and E Safety Officer	OPR Administrative Assistant	Communications Manager	DPR Chief
EMS Special Programs Coordinator	DPR Administrative Assistant	Communications Manager	All-Hazards Planning Section Chief
	EMS Administrative Assistant		

General Staff

Operations Section	Planning Section	Logistics Section	Finance and Administration Section
Title	Title	Title	Title
EMS Chief	All-Hazards Planning Section Chief	PHEOC Coordinator	FGM Chief
ERC Regional Supervisor	Evaluation Coordinator	Accounting Technician	HPP Grants Manager
HPP Program Manager			PHEP Grants Manager

IDPH ESF-8 Plan: Burn Surge Annex
Attachment 4: Burn Surge Annex Activation Pathway
November 2016

Purpose: Outline the types of incidents that prompt the activation of the Burn Surge Annex
Instructions: All stakeholders should use this pathway as a reference guide for the different avenues and types of Health and Medical Emergency Events that can trigger the activation of the Annex



* = See IDPH ESF-8 Plan for definitions of each type of Health and Medical Emergency Event
** = See Burn Surge Annex for definitions of local, regional and statewide burn MCI

ATTACHMENT 5: BURN MEDICAL INCIDENT REPORT FORM

Purpose: Assist with ensuring consistent communication between stakeholders and provide a mechanism to request burn patient transfer and identify availability of resources at a health care facility.

Instructions: When the annex is activated, this form will be utilized by **all** stakeholders (e.g. health care facilities, LHDs, IDPH, SBCC) to communicate necessary information about the incident, annex activation and burn patient transfer resource needs/requests. For burn care equipment resource needs/request, complete the ICS 213RR form and submit it through the Request for Medical Resources Process as outlined in the IDPH ESF-8 Plan.

INCIDENT NAME			
DATE/TIME PREPARED	**DATE/TIME RECEIVED**	**OPERATIONAL PERIOD**	**RECEIVED VIA** □ Phone □ Radio □ Fax □ Other
FROM (SENDER)	**TO (RECEIVER)**	**REPLY/ACTION REQUIRED?** □ YES □ NO If YES, *include detailed sending information* below **REPLY TO: □ Phone □ Radio □ Fax □ Other (List number)**	
PRIORITY □ Urgent/High □ Non-urgent/Medium □ Informational/Low			

DATE/TIME PHEOC ACTIVATED	**REASON FOR PHEOC ACTIVATION**
DATE/TIME ANNEX ACTIVATED	**REASON FOR ANNEX ACTIVATION**
ACTIVATION LEVEL □ Local □ Regional □ State	**STATE BURN COORDINATION CENTER (SBCC) NAME**
DATE/TIME SBCC ACTIVATED	**REASON FOR SBCC ACTIVATION**
CURRENT INCIDENT INFORMATION	

CURRENT NUMBER OF BURN PATIENT PLACEMENT NEEDS

The purpose of this section is to identify the number of burn patients and what type of health care facility is needed for their care during a burn MCI. These categories are for interfacility transfers only, not EMS scene transports. **Enter the total number of patients for each triage category in the corresponding boxes below. In the *Burn Patient Placement Information* section on page 2 of this Form, provide more specific information about the individual patients (tracking number, gender and age).** For more information, see Burn Surge Annex, Attachment 15: Hospital Burn Triage Guidelines: Mass Casualty Burn Center Referral Criteria.

	TRIAGE CATEGORY				
	CATEGORY 1	**CATEGORY 2**	**CATEGORY 3**	**CATEGORY 4**	**CATEGORY 5**
	HOSPITAL WITH BURN CAPABILITIES	**TRAUMA/NON BURN HOSPITAL**	**ANY ACUTE CARE HOSPITAL WITH AN ICU**	**NON-TRAUMA/ NON-BURN HOSPITAL**	**ANY ACUTE CARE HOSPITAL**
NUMBER OF PATIENTS					

ATTACHMENT 5: BURN MEDICAL INCIDENT REPORT FORM

REQUIRED/REQUESTED ACTIONS AT THIS TIME

BURN PATIENT PLACEMENT INFORMATION

The transferring health care facilities should complete this section for each patient that requires transfer/placement at another health care facility when submitting a request to the SBCC. Do not include detailed information about the patient's medical condition or treatment. Once a receiving facility has been identified, the SBCC will complete the last column and send this information back to the transferring facility.

To be Completed by the Transferring Hospital				*To be Completed by the SBCC*
Patient Tracking Number (assigned by initial health care facility)	**Triage Category (Category 1-5)**	**Gender**	**Age**	**Receiving Hospital Name** **Receiving Hospital Address**

SEND REPLY TO: □ Phone □ Radio □ Fax □ Other
(List number):

RECEIVED BY	**TIME RECEIVED**	**FORWARD TO**

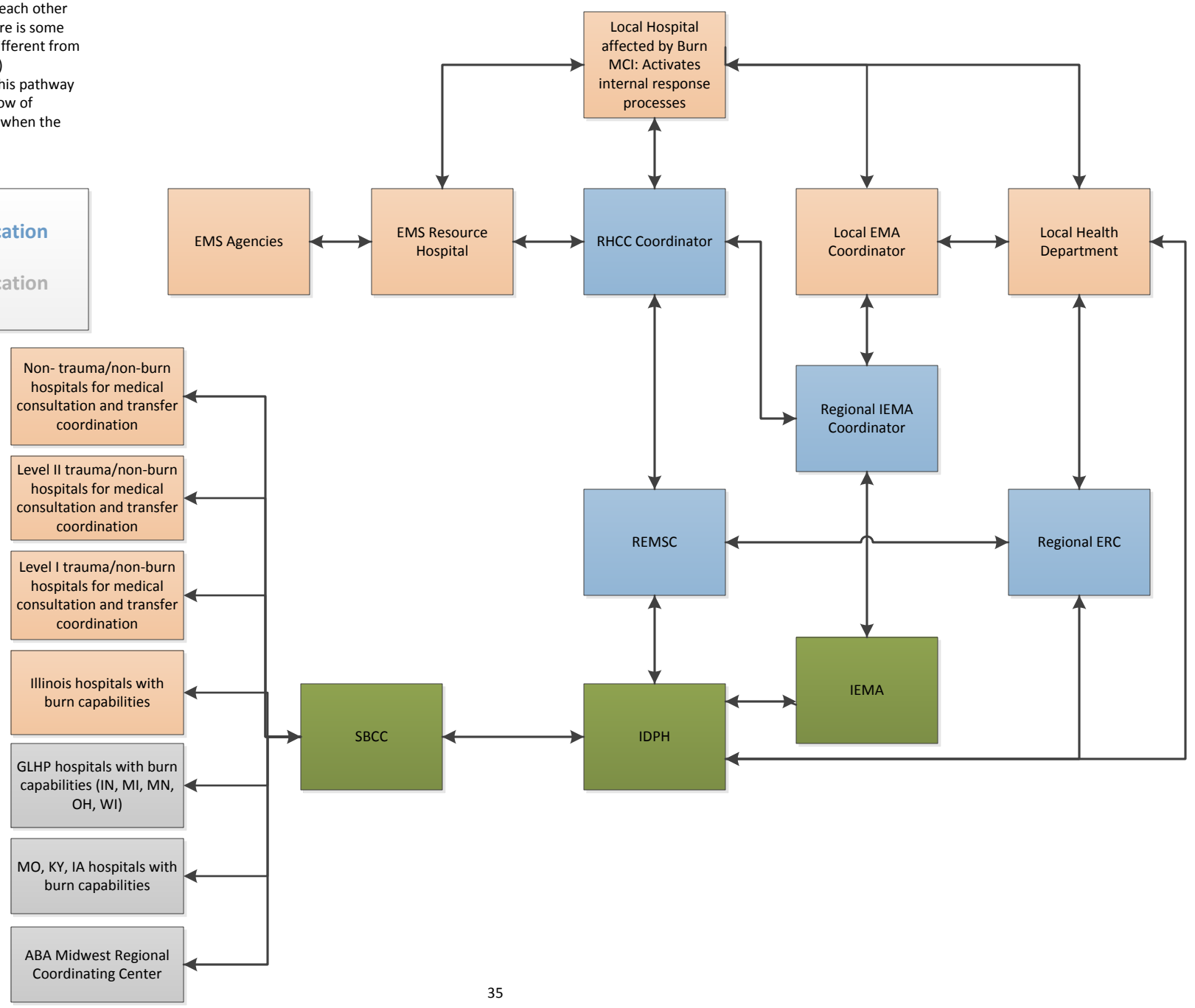
COMMENTS

FACILITY NAME/LOCATION

IDPH ESF-8 Plan: Burn Surge Annex: 2016
Attachment 6: Burn Communication Pathway
November 2016

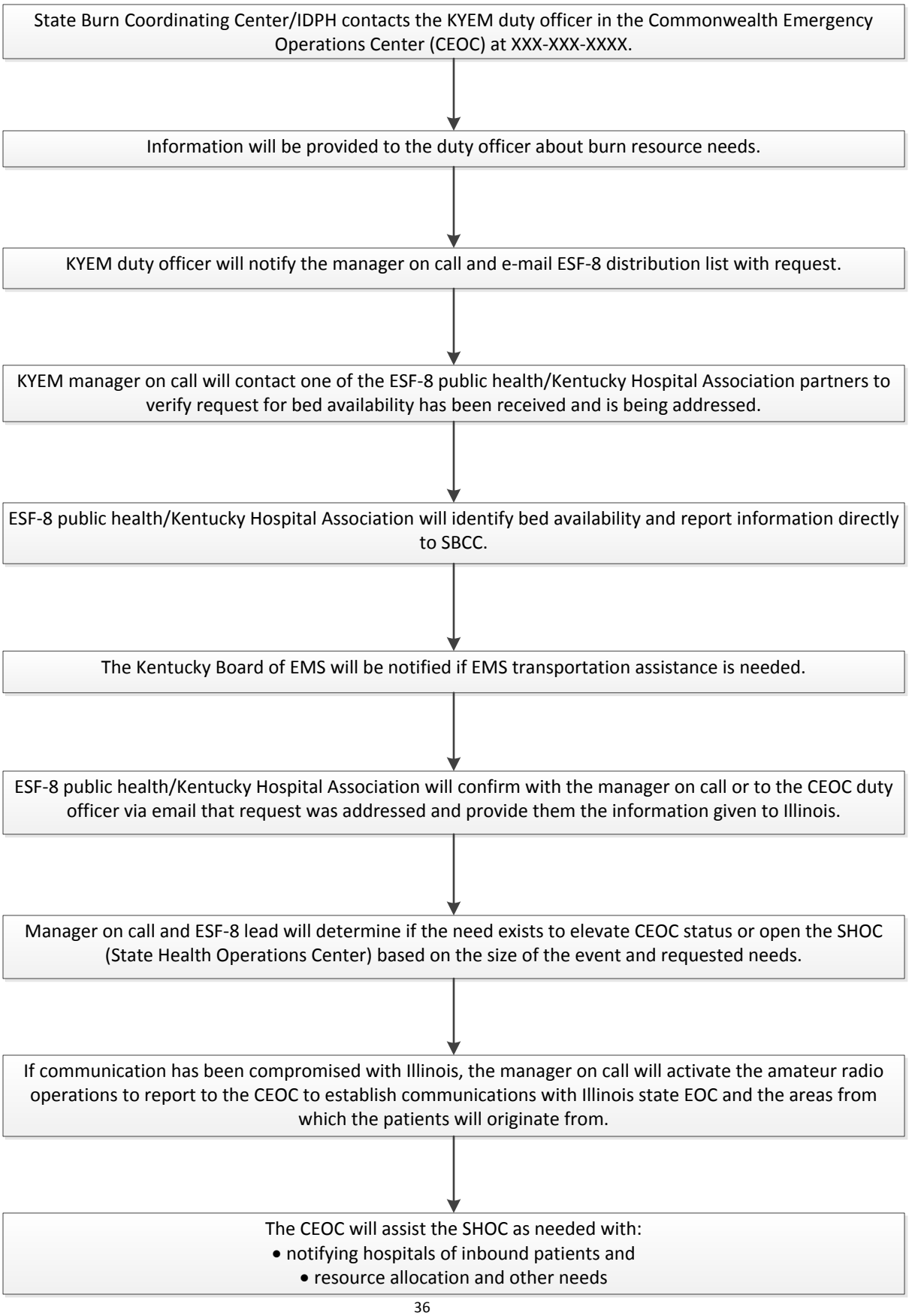
Purpose: Outline which stakeholders will typically communicate and share information with each other when the annex is activated. Although there is some overlap, this Communication Pathway is different from the Request for Medical Resources (RFMR)
Instructions: All stakeholders should use this pathway as a reference guide to identify how the flow of information/communication should occur when the annex is activated.

Local Communication
Intrastate Regional Communication
State Communication
Interstate Regional Communication



IDPH ESF-8 Plan: Burn Surge Annex: 2016
Attachment 7: Kentucky Resource Request Process
November 2016

Purpose: Outline the process to contact border states in order to facilitate communication and request resources during a disaster
Instructions: When the annex is activated, this process will be utilized by IDPH and SBCC to communicate necessary information about the incident, annex activation and resource needs/requests to Kentucky



ATTACHMENT 8: MISSOURI RESOURCE REQUEST PROCESS

Purpose: Outline the process to contact border states in order to facilitate communication and request resources during a disaster

Instructions: When the annex is activated, this process will be utilized by IDPH and SBCC to communicate necessary information about the incident, annex activation and resource needs/requests to **Missouri**.

State of Missouri:

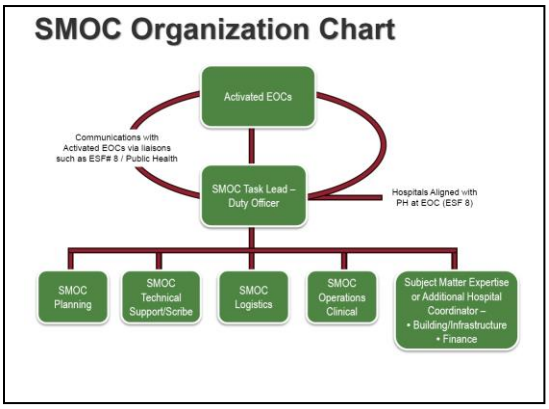
Missouri Department of Health and Senior Services' Emergency Response Center (MDHSS ERC) will serve as the primary contact for Missouri. Contact their ERC at XXX-XXX-XXXX and inform the duty officer of requested action. The duty officer will contact the appropriate personnel for response and coordination including contact with the St. Louis Medical Operations Center (SMOC) as appropriate, sending information to Missouri hospitals and assisting with coordination of burn resources and burn transport. However, it is recommended that during burn surge incidents impacting the Illinois counties of Madison, Monroe and St. Clair, Illinois also contact the SMOC as the secondary contact for Missouri.

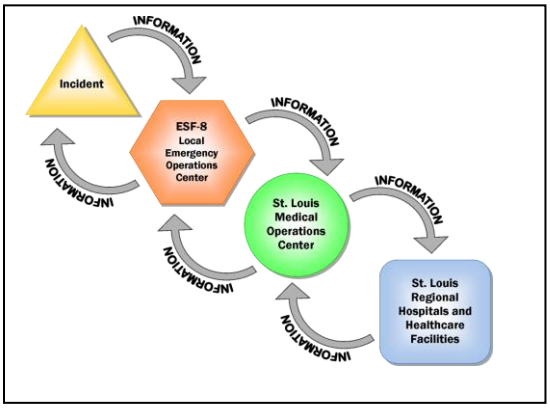
St. Louis Medical Operations Center (SMOC)

- Regional coordination entity supported and staffed by health care organizations to help coordinate decision making for hospitals when hospitals need assistance beyond their walls.
- Supported by volunteers from the medical community (administrative, clinical, non-clinical.
- During an emergency:
    - Serves as central point of contact among health care facilities, state and local emergency management agencies, and other governmental and non-governmental agencies as needed.
    - Collects and disseminates current situational information about incident and facility status.
    - Accesses health care resources and needs (e.g., equipment, bed capacity, personnel, supplies, etc.).
    - Develops priority allocations.
    - Tracks disbursement of resources.
    - Manages relevant health care response and communication.
    - Serves as advisors to other emergency support functions (ESF's) within the EOC.

Process for Communication with SMOC:

- SBCC/IDPH contacts the Central County 911 Center at XXX-XXX-XXXX and requests SMOC duty officer be contacted.
- The duty officer will then serve as the liaison to identify burn resource availability, send information to Missouri hospitals and assist with the coordination of transfers.





ATTACHMENT 8: MISSOURI RESOURCE REQUEST PROCESS

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American Burn Association Midwest Burn Region

Missouri is located in the ABA Midwest Burn Region and is part of their regional burn plan. In addition to contacting Missouri Department of Health and Senior Services' Emergency Response Center and the St. Louis Medical Operation Center (SMOC), the ABA Midwest Regional Coordinating Center should also be contacted as outlined in the Annex. The University of Nebraska Medical Center Burn Unit has been designated as the Regional Coordinating Center and may be able to offer additional assistance by sending information to the burn hospitals in its region and assist with coordination of burn resources and burn patient placement in these states. The contact phone number for the burn unit at the University of Nebraska Medical Center is XXX-XXX-XXXX.

ATTACHMENT 9: IDPH and SBCC Communication Process

Purpose: Outline the process for what, when and how information should be shared between the IDPH and the SBCC in order to facilitate communication and request resources during a disaster

Instructions: When the annex is activated, this process will be utilized by IDPH and SBCC to communicate necessary information about the incident, annex activation and resource needs/requests to each other.

Event Initiation

- The hospital initially affected by the burn mass casualty incident (MCI) will contact their Resource Hospital and their Regional Hospital Coordinating Center (RHCC) and inform them of the incident. They will provide a situational awareness report to both the RHCC and Resource Hospital which should include the following:
    - A summary of what has occurred;
    - Known and expected number of burn victims (based on EMS on scene assessment and ED receipt of transported and self-delivered patients)
        - Immediate (Red)
        - Urgent (Yellow)
        - Minor (Green)
        - Expectant/Deceased (Black)

- If the affected hospital needs additional resources to handle the burn MCI, they will contact the local Resource Hospital/RHCC. If the needs requested cannot be met at the Regional level, the affected hospital should follow the Request for Medical Resources (RFMR) process as outlined in the IDPH ESF-8 Plan by contacting the Local Health Department (LHD) and requesting assistance using the ICS 213RR form. The LHD will contact the Emergency Management Agency having jurisdiction for assistance.

- If the request cannot be handled by the local emergency management agency (EMA), the request will continue to follow the RFMR process up to the State level where the event and the request for resources will be evaluated.

- IDPH will notify Loyola University Medical Center (LUMC) that the IDPH ESF-8 Plan Burn Surge Annex is being activated and request that they function as the State Burn Coordinating Center (SBCC) while providing a situational awareness update.

    - If LUMC indicates that they are not capable of functioning in the SBCC role, the IDPH duty officer or designee, will follow the process outlined in the IDPH Duty Officer (DO) Standard Operating Guidelines (SOG) to identify a secondary SBCC.

Initial Notifications:

SBCC:

1. SBCC will notify IDPH when the SBCC is operational
2. SBCC will notify IDPH of contact information to distribute to stakeholders (e.g. phone number for medical consultation; phone/fax/email for transfer requests) via the Burn Medical Incident Report Form (Attachment 5)

IDPH:

1. IDPH will notify all stakeholders, including the other burn hospitals in Illinois of the following, utilizing the Burn Medical Incident Report Form:
   a. the incident;
   b. activation of the Burn Surge Annex, including the Hospital Burn Triage Guidelines (Attachment 15);
   c. activation of the SBCC;
   d. process to contact SBCC for medical consultation and transfer coordination requests; and
   e. request that all hospitals (especially the burn hospitals) update the electronic bed tracking system with bed availability.
2. IDPH will notify the Great Lakes Healthcare Partnership Program (GLHPP), as outlined in the Burn Surge Annex and the GLHPP Regional Burn Annex, of the burn MCI and the activation of the SBCC, informing them that the SBCC may be contacting them directly for transfer coordination assistance.
3. IDPH will notify Iowa, Kentucky, and Missouri as outlined in the Burn Surge Annex of the burn MCI and activation of the SBCC, informing them that the SBCC may be contacting them directly for transfer coordination assistance.
4. IDPH will notify the ABA Midwest Regional Coordinating Center, as outlined in the Burn Surge Annex of the burn MCI and activation of the SBCC, informing them that the SBCC may be contacting them directly for transfer coordination assistance.

Ongoing Notifications:

1. IDPH, through the Incident Management Team (IMT) Hospital Unit Lead, will provide Situational Awareness updates to the SBCC based on the defined Operational Periods unless otherwise requested. The updates will be provided using the Burn Medical Incident Report Form or verbally and will contain the following:
   a. General incident information as determined pertinent by the Public Health Emergency Operations Center (PHEOC) Incident Commander.
   b. Follow up on issues requiring IDPH assistance

2. The SBCC, through the SBCC Chief Medical Officer or designee, will provide Situational Awareness updates to IDPH based on the Operational Periods determined by IDPH. The updates will be provided using the Burn Medical Incident Report Form, verbally during conference calls or via other means of communication and will contain the following:
   1. The number of available burn beds available in the State
   2. Burn Patient Tracking Log (Attachment 13) which will provide information on:
      a. Number of burn patients transferred to another health care facility;
      b. What healthcare facility(ies) patients were transferred to and from;
      c. Number of burn patients still needing interfacility transfer.
   3. The number of medical consultations provided (through the use of the Burn Casualty Communication Log {Attachment 24}, maintained by the SBCC).
   4. Issues requiring IDPH assistance

3. The SBCC, through the SBCC Chief Medical Officer or designee, will also provide updates to the GLHPP, the States of Iowa, Kentucky, and Missouri, and the ABA Midwest Regional Coordinating Center as to burn victims being handled within the State; the numbers transferred out of State and to which State; and expected additional burn victims.

Transferring the SBCC role during an incident (Partially or fully)

Partial Transfer of SBCC Role:

There may be times during an event when the SBCC may require assistance in handling the calls for medical consultation. The SBCC can submit a request to the GLHPP to identify another state's SBCC to assist with addressing medical consultations. The Illinois SBCC would contact the GLHPP as outlined in the Burn Surge Annex and the GLHPP Regional Burn Surge Annex. IDPH will be informed by the Illinois SBCC of the need prior to contacting the GLHP for this assistance. Once the transition of the medical consultation role is made to another state's SBCC within the GLHPP, the IDPH Hospital Unit Lead will notify all stakeholders, including the other burn hospitals in Illinois of the following, utilizing the Burn Medical Incident Report Form:

1. Shared SBCC role between the Illinois SBCC and the GLHPP other state SBCC
2. The specific role of each SBCC
3. The process to contact each SBCC

Complete Transfer of SBCC Role:

If the SBCC is no longer able to function as the SBCC, the following steps need to occur:

1. The SBCC will contact the IDPH Hospital Unit Lead to inform them of the need to identify a secondary SBCC.
2. The Hospital Unit Lead will notify the PHEOC Incident Commander who will then identify and contact the secondary SBCC to request they function as the primary SBCC.
3. Once the secondary SBCC has accepted the request to begin functioning as the primary SBCC, the PHEOC Incident Commander, together with the secondary SBCC, will determine an approximate time point at which SBCC duties will be transferred.
4. The new primary SBCC will contact the Hospital Unit Lead when they are functional and able to assume duties.
5. The Hospital Unit Lead will then contact LUMC to inform them of activation of a new primary SBCC and that SBCC duties will now be transferred to the new primary SBCC.
6. The Hospital Unit Lead will notify all stakeholders, including the other burn hospitals in Illinois of the following, utilizing the Burn Medical Incident Report Form:
    a. The activation of the new primary SBCC; and
    b. The process to contact the new primary SBCC for medical consultation and transfer coordination requests.

IDPH ESF-8 Plan: Burn Surge Annex: 2016
Attachment 10: IDPH & SBCC Communication Process Algorithm
November 2016

Purpose: Outline the process for what, when and how information should be shared between the IDPH and the SBCC in order to facilitate communication and request resources during a disaster
Instructions: When the annex is activated, this process will be utilized by IDPH and SBCC to communicate necessary information about the incident, annex activation and resource needs/requests to each other

Initial Notification Process

Resources become exhausted on local and regional level

RFMR process followed and IDPH activates the Burn Surge Annex

IDPH Duty Officer (DO) or designee contacts LUMC and requests they function as the SBCC

LUMC able to function as SBCC

LUMC notifies IDPH and provides contact information (phone number for medical consultation, phone/fax/email for transfer requests via Burn Medical Incident Report Form (Attachment 5)

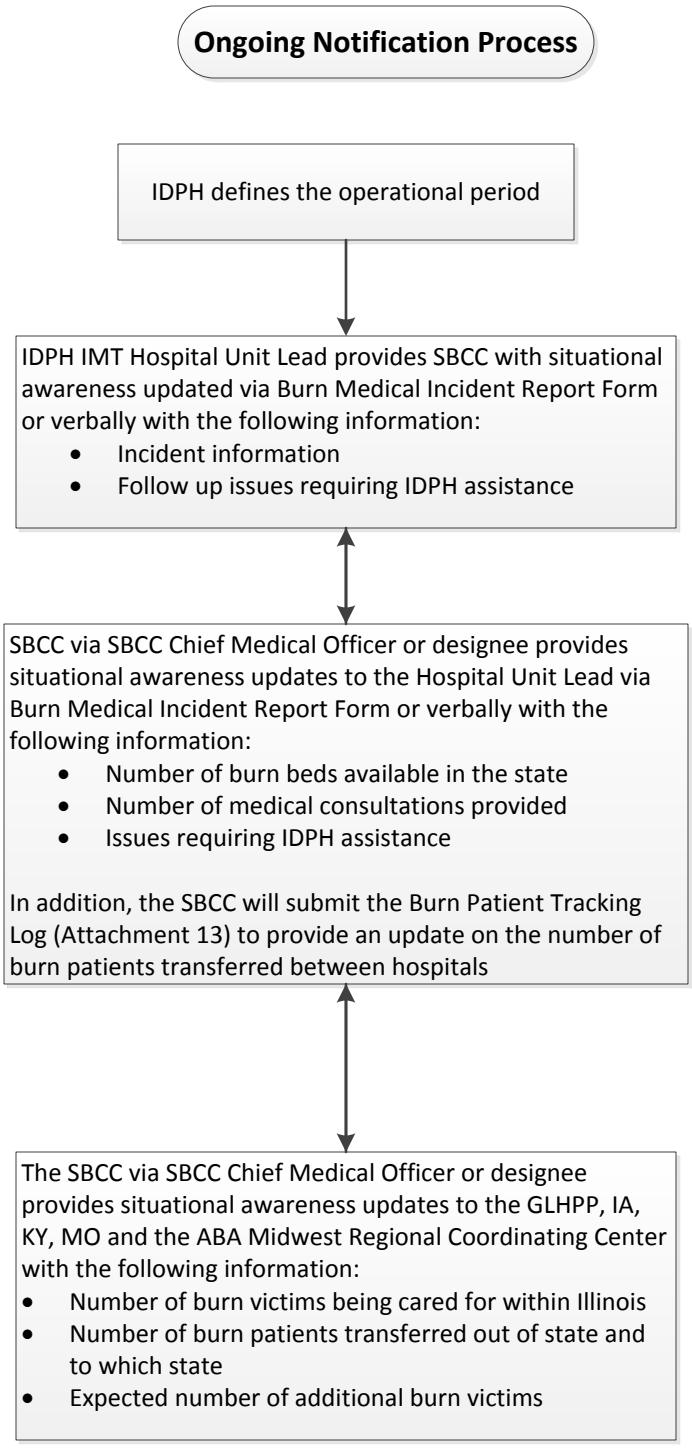
IDPH

- Uses the Burn Medical Incident Report Form to notify all stakeholders about the following:
  - The incident
  - Activation of the Annex
  - Activation of the Burn Triage Guidelines
  - Activation of the SBCC
  - Process to contact the SBCC for medical consultation and transfer coordination
- Notifies the border states (GLHPP, IA, KY MO, and the ABA Midwest Regional Coordinating Center) as outlined in the Annex about the following:
  - The incident
  - Activation of the Annex
  - Activation of the SBCC
  - SBCC will contact them directly for transfer coordination assistance

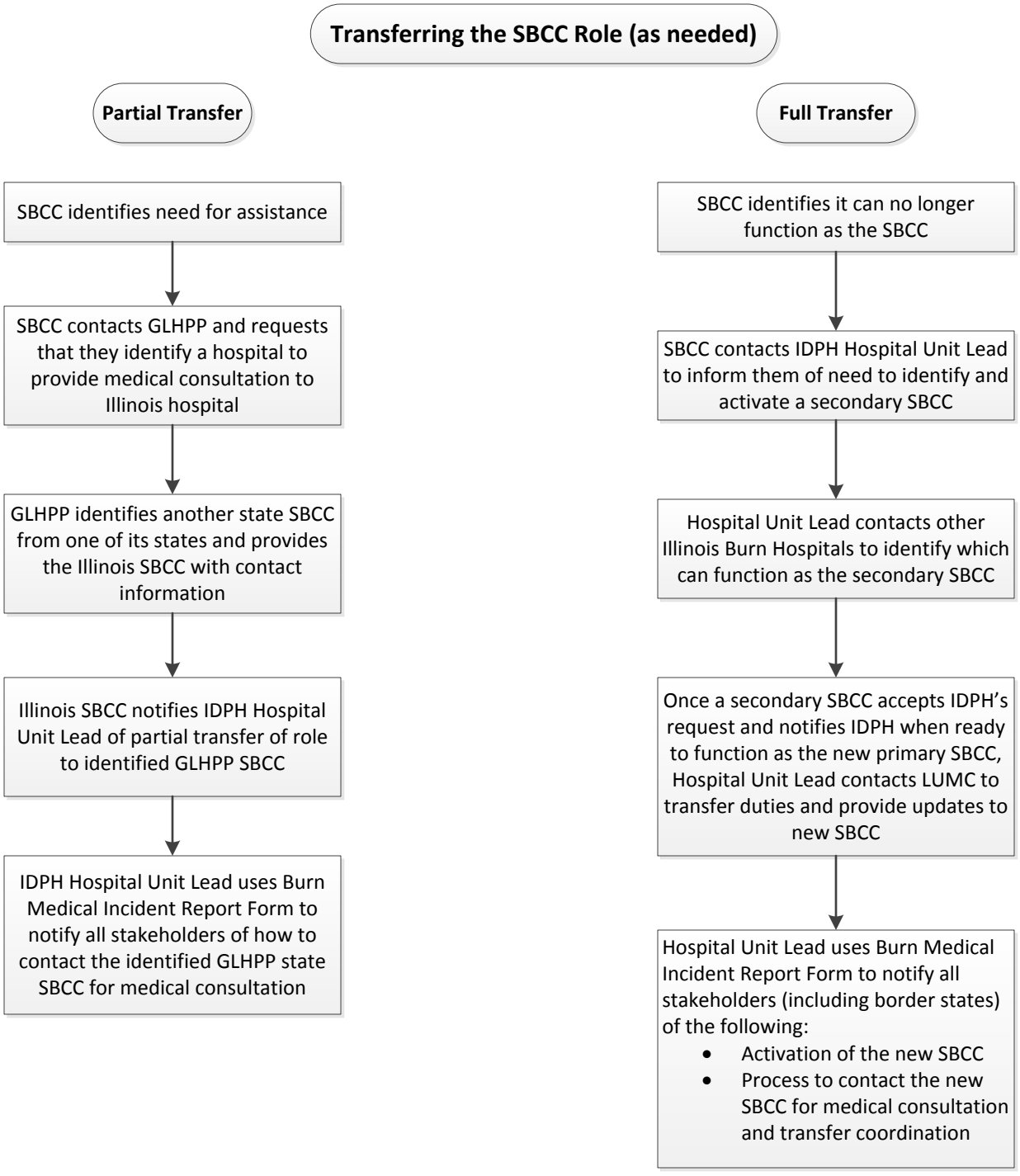
LUMC not able to function as SBCC

IDPH Duty Officer follows process outlined in DO SOG to identify a secondary SBCC

IDPH ESF-8 Plan: Burn Surge Annex: 2016
Attachment 10: IDPH & SBCC Communication Process Algorithm
November 2016



IDPH ESF-8 Plan: Burn Surge Annex: 2016
Attachment 10: IDPH & SBCC Communication Process Algorithm
November 2016



ATTACHMENT 11: ILLINOIS BURN RESOURCE DIRECTORY

Purpose: Provide a listing of the five hospitals with burn capabilities within Illinois a long with a quick reference to each facility's capabilities and contact information.
Instructions: All stakeholders should use this resource directory as a reference guide when the annex is activated to identify the hospitals with burn capabilities and their contact information

HOSPITALS WITH BURN CAPABILITIES	BURN TRANSFER PHONE	TRAUMA CENTER LEVEL	EMS REGION	PEDIATRIC BURN CRITICAL CARE CAPABILITY	NUMBER OF BURN BEDS
ADDRESS	BURN UNIT PHONE		PHMSRR*		TOTAL SURGE BED CAPACITY
	SECURE EMAIL ADDRESS				
STATE BURN COORDINATING CENTER (SBCC) Loyola University Medical Center[V]	XXX-XXX-XXXX	Level I	8	Y	10 ICU, 11 step-down
2160 S. First Ave. Maywood, IL 60153	XXX-XXX-XXXX		Chicago		Total: 32-33
	XXXX@lumc.edu				
John H. Stroger, Jr. Hospital of Cook County [V] Summer L. Koch Burn Center	XXX-XXX-XXXX	Level I and Pediatric Level I	11	Y	6 Adult ICU, 10 PICU, 10 step-down
1901 W. Harrison St. Chicago, IL 60612	XXX-XXX-XXXX		Chicago		Total: 30-35
Memorial Medical Center Regional Burn Center SIU School of Medicine	XXX-XXX-XXXX	Level I	3	N	8 Universal (ICU, step down, medical)
701 N. First St. Springfield, IL 62781	XXX-XXX-XXXX5		Springfield		Total: 10
	XXXX@mhsil.com				
OSF St. Anthony Medical Center	XXX-XXX-XXXX	Level I	1	N	8 ICU
5666 E. State St. Rockford, IL 61108	XXX-XXX-XXXX		Rockford		Total: 14
University of Chicago Medical Center[V]	XXX-XXX-XXXX	Pediatric Level I	11	Y	8 ICU, 8 Medical
5841 S. Maryland Ave. Chicago, IL 60637	XXX-XXX-XXXX		Chicago		Total: 20
	XXX@uchospitals.edu				

V=American Burn Association Verified Burn Center * Public Health and Medical Services Response Regions

ATTACHMENT 12: PATIENT IDENTIFICATION TRACKING FORM

Purpose: Assist in identifying, tracking and reunifying patients during a disaster.

Instructions: This form should be completed to the best of the provider's ability given the information available on all patients, especially pediatric patients, who arrive at a health care facility even if accompanied by family/parent/guardian. Send the original form with the patient if transferred to another facility and keep a copy of the form on file with the patient's medical record at the transferring health care facility.

Note: Information contained within this form is confidential and should not be shared, except with those assisting in the care of the patient.

Date of Arrival _____/_____/_____	Time of Arrival AM/PM	Incident name
Tracking number (assigned by initial health care facility)		
Patient's Name (Last, First)		Patient's Phone
Patient's Full Home Address		
(For Minors) Parent/Guardians' Names		Presented with patient? □ Yes □ No
Patient's DOB / / □ Unknown	Age ___Years ___Months □ Estimated	Gender □ Male □ Female
Race/ethnicity, if known □ White non-Hispanic □ Black/African American, non-Hispanic □ Asian or Pacific Islander □ Hispanic □ Asian Indian □ American Indian or Alaska Native □ Unknown □ Other _____		Language □ English □ Spanish □ Nonverbal □ Other _____

□ Accompanied □ Unaccompanied	Describe where patient was found (be as specific as possible, including neighborhood/street address).	Items worn by or with patient when found (describe color, pattern, type) □ Pants_____ □ Shirt_____ □ Dress _____ □ Shoes _____ □ Socks _____ □ Coat/Jacket _____ □ Jewelry_____ □ Glasses_____ □ Medical Devices_____ □ Other _____ □ Other _____
How patient arrived at hospital (list name if available) □ EMS_____ □ Private medical transport service (ambulance/flight)_____ _____ □ Law Enforcement _____ _____ □ Private Vehicle □ Walk-in □ Other_____		

DESCRIPTION OF THE PATIENT

Skin color_____	Attach photo here
Hair Color □ Bald □ Black □ Blonde □ Brown □ Red □ Grey □ White □ Other_____	
Eye Color □ Brown □ Blue □ Green □ Other_____	
Height □Estimated	
Weight □Estimated	
Other markings □ Scars_____ □ Moles_____ □ Birthmarks _____ □ Tattoos_____ □ Missing teeth_____ □ Braces_____ □ Other_____ □ Other_____	

PATIENT TRACKING LOG

Hospital/Facility Name **Location (city, state)**	**Phone Number** **Fax Number**	**Arrival Date** **Departure Date**	**ID Band #/ ID Band** *(If patient has ID bands from other facilities and they need to be removed to provide care, attach ID band in this area)*
	( )	____/____/____	Attach ID Band Here
	( )	____/____/____	
	( )	____/____/____	Attach ID Band Here
	( )	____/____/____	

ATTACHMENT 12: PATIENT IDENTIFICATION TRACKING FORM

MEDICAL HISTORY AND TREATMENT WHILE AT THIS FACILITY

Does the patient have any pre-existing medical conditions/medical problems/previous surgeries/special needs?
□ No □ Unknown □ Yes (list)

Is the patient on any medications? □ No □ Unknown □ Yes (list)

Does the patient have any allergies? □ No □ Unknown □ Yes (list)

Did the patient receive medical care for an injury/illness while at this facility?
□ No □ Yes (list)

COMPLETE FOR MINORS: CHILD ACCOMPANIED BY PARENT/GUARDIAN

Name of Person Accompanying Child □ Adult □ Child/Minor

Relationship to Child
□ Parent □ Guardian □ Sibling □ Grandparent
□ Aunt/Uncle/Cousin □ Unknown
□ Other _____

Attach Copy of ID

ID Checked? □ Yes □ No
Form of ID (list)_____

If accompanied by adult, was child living with this adult prior to the emergency? □ Yes □ No
Does this adult have any proof of legal guardianship or relationship? □ Yes □ No
If yes, make copy and attach to this form.

If child and adult were separated after arrival at current facility, where is accompanying adult now?

If accompanied by someone other than parent/guardian, what is known about the parent/guardian's current whereabouts?
□ Nothing at this time □ Their current location is:

Is it known if there are orders of protection or other custody issues? □ No known custody/protection issues
□ Issue(s) identified

COMPLETE FOR MINORS: CHILD UNACCOMPANIED BY PARENT/GUARDIAN

Are the whereabouts of the parent/guardian currently known? □ No □ Yes
Is information about parent/guardian known? □ No □ Yes
Name Phone
Location
E-mail Address

Where and when was the parent/guardian last seen

Has the parent/guardian been contacted □ No □ Yes
Contacted by_____ Date __/__/____ Time _____

Plans for reuniting child with parent/guardian

Agencies Used to Assist with Reunification (Date/Person Contacted)
□ American Red Cross _____
□ Department of Children and Family Services_____
□ Law enforcement_____
□ National Center for Missing and Exploited Children
_____
□ Other_____

Additional steps to verify guardianship if reunited at hospital
□ Does parent/guardian describe child accurately?
□ Does parent/guardian pick correct child out from a group of pictures?
□ Does parent/guardian have a picture of them with the child?
□ Does the child respond appropriately when reunited with parent/guardian?

DISPOSITION

□ Admitted to_____ □ Discharged □ Expired
□ Patient was released to an individual □ Parent □ Guardian □ Other_____
Name Phone License Plate Number
Address □ Permanent □ Temporary
Was consent obtained from parent/guardian if released to another adult? □ Yes □ No (explain)_____

□ Patient was transferred to another facility/agency (Name)_____
Address Phone
Contact Name
Transported by

Signature of patient/individual patient released to	Date:__ / __/ ____ Time	Name of Person Completing Form Signature of Person Completing Form

ATTACHMENT 13: BURN PATIENT TRACKING LOG

Purpose: Assist with the tracking of burn patients during a disaster.

Instructions: A designated subject matter expert at the State Burn Coordinating Center (SBCC) will complete this form on all patients that the SBCC assists with transfer coordination between two health care facilities. This form will be used as a reference for the SBCC and IDPH to assist in the reunification of patients with their families. At the end of each operational period (or other agreed upon designated time frame), the SBCC will forward this completed form to IDPH IMT at the Public Health Emergency Operations Center (PHEOC), who will maintained it in the same manner as other incident related documents.

Note: Information contained within this form is confidential and should not be shared, except with those assisting in the care of the patient.

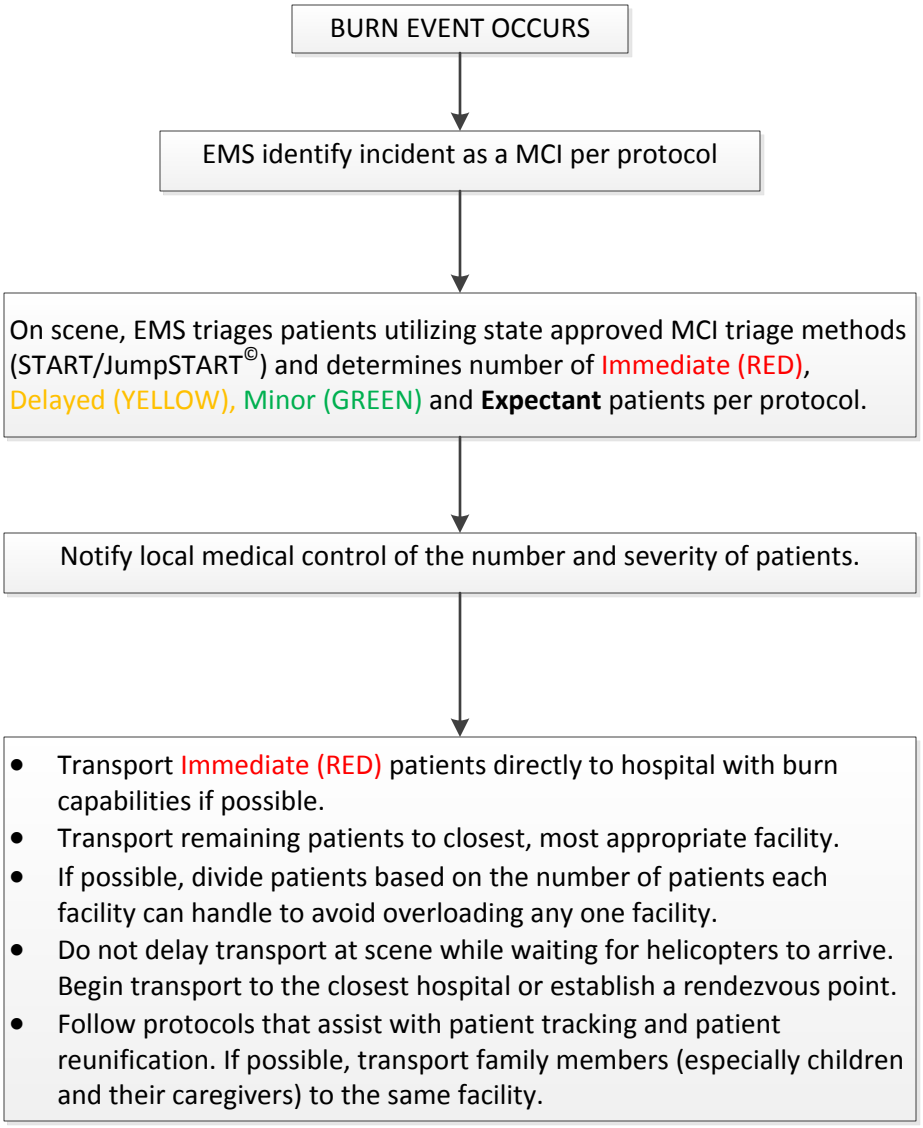
Incident name		**Prepared by**						**Date**			**Time**	
Tracking Number (assigned by initial health care facility)	**Patient Name (Last, First)**	**DOB**	**% TBSA**	**Ventilated**	**Burn Injury Depth** / **Burn Injury Location**	**Inhalation Injury**	**Other Injuries** (Trauma)	**Triage Category** (Category 1-5)	**Method of Transport** (Ground, Air) / **Type of Transport** (BLS, ALS, Critical Care)	**Transferring Facility** / **POC at Transferring Facility**	**Assigned Receiving Facility** / **POC at Receiving Facility**	**Transfer Complete (Time)**
				Y N		Y N						
				Y N		Y N						
				Y N		Y N						
				Y N		Y N						
				Y N		Y N						

ATTACHMENT 13: BURN PATIENT TRACKING LOG

Incident name		**Prepared by**						**Date**			**Time**	
Tracking Number (assigned by initial health care facility)	**Patient Name (Last, First)**	**DOB**	**% TBSA**	**Ventilated**	**Burn Injury Depth** **Burn Injury Location**	**Inhalation Injury**	**Other Injuries (Trauma)**	**Triage Category (Category 1-5)**	**Method of Transport (Ground, Air)** **Type of Transport** (BLS, ALS, Critical Care)	**Transferring Facility** **POC at Transferring Facility**	**Assigned Receiving Facility** **POC at Receiving Facility**	**Transfer Complete (Time)**
				Y N		Y N						
				Y N		Y N						
				Y N		Y N						
				Y N		Y N						

IDPH ESF-8 Plan: Burn Surge Annex: 2016
Attachment 14: EMS Burn Triage Guidelines
November 2016

Purpose: Provide EMS, SBCC and health care facilities guidance on how EMS should determine which type of hospital is the most appropriate facility to transport burn patients to during a burn MCI.
Instructions: This guideline should be used by EMS to assist with responding to a burn MCI and assist the SBCC and health care facilities with understanding how patients may be distributed from a burn MCI scene.
Disclaimer: This guideline is not meant to be all inclusive, replace an existing EMS regional or system SOP/policy/procedure, or substitute for clinical judgement.



ATTACHMENT 15: HOSPITAL BURN TRIAGE GUIDELINES

Purpose: Provide the SBCC and health care facilities guidance on determining which type of hospital is the most appropriate facility to transfer burn patients to during a burn MCI.

Instructions: Transferring physicians and the SBCC should use these guidelines to determine which type of health care facility would be the most appropriate to meet the burn care needs of patients when the annex is activated. The triage category assigned to each patient by the transferring physician should be sent to the SBCC using the Burn Medical Incident Report Form (Attachment 5)

Hospital Burn Triage Guidelines: Mass Casualty Burn Center Referral Criteria

During a mass casualty burn incident as defined in this annex, standard burn center referral criteria may need to be altered if the burn resources within Illinois become overwhelmed due to the volume of critically ill and injured burn patients. The Mass Casualty Burn Center Referral Criteria listed below should be utilized to provide guidance when determining what type of facility burn patients should be transferred to based on their injuries. These categories are intended to assist with making interfacility transfer decisions only-not EMS transport decisions from the initial scene. See Attachment 14 for EMS Burn Triage Guidelines for guidance for scene transport decisions.

INSTRUCTIONS:

After initial stabilization measures, a primary and secondary assessment have been completed by the treating physician at the transferring health care facility, all burn patients should be placed in one of the five triage categories listed below. The triage category for all patients needing transfer to a different health care facility should be communicated to the SBCC utilizing the Burn Medical Incident Report Form (Attachment 5).

CATEGORY 1: ***CRITICAL BURN PATIENTS THAT NEED TO BE TREATED AT HOSPITALS WITH BURN CAPABILITIES:***

1. Partial thickness burns greater than or equal to 40% total body surface area (TBSA).
2. Circumferential full-thickness burns involving two or more extremities.
3. High voltage (> 1000 volt) electrical burns.
4. Burn injury in patients with preexisting medical disorders or other issues that could complicate management, prolong recovery or affect mortality (e.g., diabetes, chronic renal failure, congestive heart failure).
5. Pediatric (children ≤ 15 years of age) with burns greater than or equal to 20% TBSA.
6. Pregnant women with greater than or equal to 10% TBSA.
7. Any patients with burns and concomitant trauma (such as fractures) in which the burn injury poses the greatest risk of morbidity or mortality.

CATEGORY 2: ***CRITICAL BURN PATIENTS THAT CAN BE TREATED AT HOSPITALS WITH TRAUMA CAPABILITIES, BUT NO BURN CAPABILITIES:***

1. Partial thickness burns greater than 10% but less than 40% TBSA.
2. Circumferential full-thickness burns involving one extremity.
3. Any full-thickness burns, including full thickness, involving the face, hands, feet, genitalia, perineum or major joints.
4. Electrical burns, including lightning injury if < 1000 volts.
5. Chemical burns.
6. Any patients with burns and concomitant trauma in which the burn injury **does not** pose the greatest risk of morbidity or mortality.
7. Pediatric (children < 15 years of age) with burns greater than 10%, but less than 20% TBSA.
8. Burn injury in patients who will require special social, emotional or long-term rehabilitative intervention.
9. Pregnant women with less than 10% TBSA.

CATEGORY 3: PATIENTS WITH INHALATION INJURIES WITHOUT CUTANEOUS BURNS THAT CAN BE TREATED AT ANY HOSPITAL WITH AN ICU WITH VENITLATOR CAPABILITIES.

ATTACHMENT 15: HOSPITAL BURN TRIAGE GUIDELINES

CATEGORY 4: BURN PATIENTS THAT CAN BE TREATED AT ANY ACUTE CARE HOSPITAL

1. Partial thickness burns less than or equal to 10% TBSA.

CATEGORY 5: EXPECTANT BURN PATIENTS THAT CAN BE TREATED AT ANY ACUTE CARE HOSPITAL

The following table should be utilized by providers to assist in determining which patients could be categorized as *Category 5: Expectant Burn Patients That Can Be Treated at Any Acute Care Hospital* during a burn MCI. The information in the table should not be substituted for clinical judgment. This table should **only** be used as a guide to categorize expectant patients, not to categorize patients into the other 4 categories listed above. The definitions for the categories within the table can be found below the table. In addition to using age and % TBSA in the table below, categorizing patients as "*Category 5: Expectant"* may vary based on individual patient's response to treatment, available resources to treat burn patients during a burn MCI, and the extent of additional non-burn injuries that the patient has. Therefore, it may be possible that the table indicates a patient would not be considered *Expectant* but based on additional information about the patient's additional injuries, the circumstances of the incident (available resources) and the provider's clinical judgement, the patient would be categorized as "*Category 5: Expectant"*. For assistance and further guidance, contact the State Burn Coordinating Center (SBCC).

To use the table below, determine the age of the patient and the extent of their burn injuries (% TBSA). If the patient also has inhalation injuries, add 10% to the % TBSA before using the table. For example, if a 20 year old has 80% TBSA and also has inhalation injuries, it should be considered a 20 year old with 90% TBSA. Using the age and the % TBSA or adjusted % TBSA, identify if the patient is categorized as *Expectant*.

AGE (years)	% TOTAL BODY SURFACE AREA BURN**										
	0-10	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-90	91-99	100%
< 2	High	High	Medium	Medium	Medium	Medium	Low	Low	Low	Low	Expectant
2-5	High	High	High	Medium	Medium	Medium	Medium	Low	Low	Low	Expectant
5-19.9	High	High	High	High	Medium	Medium	Medium	Medium	Medium	Low	Expectant
20-29.9	High	High	High	High	Medium	Medium	Medium	Medium	Low	Low	Expectant
30-39.9	High	High	High	Medium	Medium	Medium	Medium	Medium	Low	Low	Expectant
40-49.9	High	High	High	Medium	Medium	Medium	Medium	Low	Low	Low	Expectant
50-59.9	High	High	High	Medium	Medium	Medium	Low	Low	Expectant	Expectant	Expectant
60-69.9	High	High	Medium	Medium	Medium	Low	Low	Low	Expectant	Expectant	Expectant
>70	High	Medium	Medium	Low	Low	Expectant	Expectant	Expectant	Expectant	Expectant	Expectant

High: Survival and good outcome expected (survival > 90%) with limited/short-term initial admission and resource allocation (length of stay, <14 days, one to two surgical procedures)
Medium: Survival and good outcome likely (survival, >50%) with aggressive care and comprehensive resource allocation, including initial admission (> 14 days), resuscitation, multiple surgeries
Low: Survival and good outcome <50%, even with long-term, aggressive treatment and resource allocation
Expectant: Survival < 10% even with unlimited, aggressive treatment
**This table was modified from the American Burn Associations' Age/TBSA Survival Grid

ATTACHMENT 16: Distributing Burn Patients to Trauma/Non-Burn Hospitals

Purpose: The purpose of this document is to assist the SBCC in distributing burn patients triaged as Category 2 and Category 3 based on the Hospital Triage Guidelines: Mass Casualty Burn Center Referral Criteria (Attachment 15) to Illinois Level 1 and Level 2 Trauma Centers during a burn MCI

Instructions: This document contains a summary of the Illinois Level 1 and Level 2 Trauma Center criteria as found in the EMS Administrative Code, sections 515.2030, 515.2035, 515.2040, and 515.2045, as well as a list of hospitals with these designations to aid the SBCC in deciding which burn patients would be appropriate for these centers. This does not replace a direct phone call to ensure that facility has the resources available to care for this type of patient.

Trauma Center Criteria for Level 1 designated hospitals

- Trauma Surgeon or 4th or 5th year surgical resident in house 24 hours a day.
- A physician with current ATLS verification for initial resuscitation in house 24 hours a day
- Surgical services:
  - On call to treat the patient within 30 minutes after notification :
    - Cardiothoracic
    - Obstetrics
    - Pediatric surgery or by transfer agreement.
  - On call to treat the patient within 60 minutes after notification:
    - Orthopedic
    - Vascular
    - Ophthalmologic
    - Oral-Dental
    - Otorhinolaryngologic
    - Plastic/maxillofacial
    - Urologic
    - Reimplantation service, or a transfer agreement
    - Neurosurgical
    - Cardiology
    - Pediatrics
    - Internal medicine
  - Twenty-four hours a day, or a transfer agreement:
    - Burn center staffed by Registered Nurses trained in burn care; and
    - Acute spinal cord injury management.
  - An operating room shall be staffed in-house and available 24 hours a day
  - Nonsurgical services:
    - Emergency Medicine staffed 24 hours a day in the ED
    - Anesthesiology Services available 24 hours a day in-house.
    - Radiology services
      - Ability to perform a computerized axial tomography (CAT) scan in-house, 24 hours a day.
      - A radiologist in house/off site with the ability to read CAT scans and perform angiography available within 30 minutes.
    - Intensive Care Medicine Unit (ICU) capabilities 24 hours a day:
    - Laboratory 24 hours a day in-house
    - Post-anesthetic recovery capabilities 24 hours a day.
    - Acute hemodialysis capability 24 hours a day.

    - Other staff shall include
        - occupational therapy
        - speech therapy
        - physical therapy
        - social work
        - dietary
        - psychiatry
- Specialized equipment: equipment:
    - Electrocardiograph-oscilloscope-defibrillator
    - Apparatus to establish central venous pressure monitoring
    - Sterile surgical instruments or sets for emergency care, such as cricothyrotomy, tracheostomy, thoracotomy, thoracostomy, cut down, peritoneal lavage, and intraosseous
    - Spinal immobilization equipment
    - Temperature control device
    - Electronic pressure monitoring;
    - Pulmonary function measuring devices
    - Intracranial pressure monitoring devices
    - Intra-aortic balloon pump capability.

Trauma Center Criteria for Level 2 designated hospitals

- Trauma surgeon who is available to arrive to the hospital within 30 minutes of trauma activation
- A physician with current ATLS verification or who has current competency in the initial resuscitation of the trauma patient must be present 24 hours per day in the Level II Trauma Center to treat the trauma patient.
- Surgical services on call to arrive at the hospital to treat the patient within 60 minutes after notification:
    - Cardiothoracic
    - Orthopedic
    - Urologic
    - Obstetrics.
- Services on call to the hospital to arrive within 60 minutes after notification or have a written transfer agreement.
    - Neurosurgical
    - Ophthalmologic
    - Oral-Dental
    - Otorhinolaryngologic
    - Reimplantation
    - Plastic/Maxillofacial
    - Burn center staffed by Registered Professional Nurses trained in burn care
    - Acute spinal cord injury management
    - Pediatric surgery
    - Cardiology
    - Internal medicine
    - Pediatrics
- An operating room shall be staffed and available within 30 minutes 24 hours a day

- Nonsurgical services:
  - Emergency Medicine staffed 24 hours a day in the ED
  - Anesthesiology Services
  - Laboratory – 24 hours a day in-house:
  - Radiology staffed by:
    - A technician with the ability to perform a CAT scan available within 30 minutes
    - A radiologist with the ability to read CAT scans and perform angiography available within 60 minutes (on or off site).
  - Post-anesthetic recovery capability staffed and available within 30 minutes Intensive Care Medicine Unit
  - Acute hemodialysis capability 24 hours a day or a transfer agreement.
  - Other staff shall include:
    - Occupational therapy
    - Speech therapy
    - Physical therapy
    - Social work
    - Dietary
    - Psychiatry
  - Specialized equipment:
    - Electrocardiograph-oscilloscope-defibrillator
    - Apparatus to establish central venous pressure monitoring
    - Sterile surgical sets of procedures standard for ED, such as cricothyrotomy, tracheostomy, thoracotomy, cut down, peritoneal lavage, and intraosseous
    - Spinal immobilization equipment
    - Temporary pacemaker
    - Temperature control device
    - Pulmonary function measuring devices

ATTACHMENT 16: Distributing Burn Patients to Trauma/Non-Burn Hospitals

Purpose: The purpose of this document is to assist the SBCC in distributing burn patients triaged as Category 2 and Category 3 based on the Hospital Triage Guidelines: Mass Casualty Burn Center Referral Criteria (Attachment 15) to Illinois Level 1 and Level 2 Trauma Centers during a burn MCI

Instructions: This document contains a summary of the Illinois Level 1 and Level 2 Trauma Center criteria as found in the EMS Administrative Code, sections 515.2030, 515.2035, 515.2040, and 515.2045, as well as a list of hospitals with these designations to aid the SBCC in deciding which burn patients would be appropriate for these centers. This does not replace a direct phone call to ensure that facility has the resources available to care for this type of patient.

Designated Trauma Hospitals

Below is a list of all the Level I and Level II Trauma Centers that are part of the Illinoi Trauma System, where they are located (region and address) and a primary contact phone number, which in most cases, is the phone number to their incident command center. A secondary number to each hospital's emergency department is also included. However, during a burn MCI, the emergency department of these hospitals will likely be overwhelmed and may have limited capacity to assist the SBCC. Therefore, this number should only be used if no one can be reached at the primary number. For some hospitals, the emergency department phone number has been identified as the primary contact number.

EMS Region	DESIGNATED TRAUMA LEVEL	HOSPITAL	ADDRESS	PRIMARY CONTACT PHONE NUMBER (HOSPITAL INCIDENT COMMAND CENTER)	SECONDARY CONTACT PHONE NUMBER (EMERGENCY DEPARTMENT PHONE NUMBER)
1	I	Rockford Health System	2400 N Rockton Rockford, Illinois 61103	XXX-XXX-XXXX	XXX-XXX-XXXX
	I	OSF Saint Anthony Medical Center	5666 E State St Rockford, Illinois 61108	XXX-XXX-XXXX	XXX-XXX-XXXX
	II	Mercy Medical Center	250 Mercy Dr Dubuque, Iowa 52001	XXX-XXX-XXXX	XXX-XXX-XXXX
	II	Swedish American Health System	1401 E State St Rockford, Illinois 61104	XXX-XXX-XXXX	XXX-XXX-XXXX
2	I Pediatric Level I	OSF Saint Francis Medical Center	530 NE Glen Oak Ave Peoria, Illinois 61637	XXX-XXX-XXXX	XXX-XXX-XXXX
	II	Advocate BroMenn Medical Center	1304 Franklin Ave Normal, Illinois 61761	XXX-XXX-XXXX	XXX-XXX-XXXX
	II	Galesburg Cottage Hospital	695 N Kellogg St Galesburg, Illinois 61401	XXX-XXX-XXXX	XXX-XXX-XXXX
	II	Genesis Medical Center – Silvis	801 Illini Dr Silvis, Illinois 61282	XXX-XXX-XXXX	XXX-XXX-XXXX
	II	OSF St. Joseph Medical Center	2200 E Washington St Bloomington, Illinois 61701	XXX-XXX-XXXX	XXX-XXX-XXXX

ATTACHMENT 16: Distributing Burn Patients to Non-Burn Hospitals

EMS Region	DESIGNATED TRAUMA LEVEL	HOSPITAL	ADDRESS	PRIMARY CONTACT PHONE NUMBER (HOSPITAL INCIDENT COMMAND CENTER)	SECONDARY CONTACT PHONE NUMBER (EMERGENCY DEPARTMENT PHONE NUMBER)
	II	OSF St. Mary Medical Center	3333 N Seminary St Galesburg, Illinois 61401	XXX-XXX-XXXX	XXX-XXX-XXXX
	II	Unity Point Heath – Methodist	221 NE Glen Oak Ave Peoria, Illinois 61636	XXX-XXX-XXXX	XXX-XXX-XXXX
	II	Unity Point Health – Trinity	2701 17th St Rock Island, Illinois 61201	XXX-XXX-XXXX	XXX-XXX-XXXX
3	I	Memorial Medical Center	701 N First St Springfield, Illinois 62781	XXX-XXX-XXXX	XXX-XXX-XXXX
	I	HSHS St John's Hospital	800 E Carpenter St Springfield, Illinois 62769	XXX-XXX-XXXX	XXX-XXX-XXXX
	II	Blessing Hospital	Broadway @ 11th St Quincy, Illinois 62305	XXX-XXX-XXXX	XXX-XXX-XXXX
4	I	Barnes – Jewish Hospital	1 Barnes-Jewish Hospital Plaza St. Louis, Missouri 63110	XXX-XXX-XXXX	XXX-XXX-XXXX
	I	St. Louis University Hospital	3635 Vista Ave St. Louis, Missouri 63110	XXX-XXX-XXXX	XXX-XXX-XXXX
	Pediatric Level I	SSM – Cardinal Glennon Children's Medical Center	1465 S Grand Blvd St. Louis, Missouri 63110	XXX-XXX-XXXX	XXX-XXX-XXXX
	Pediatric Level I	St. Louis Children's Hospital	One Children's Place St. Louis, Missouri 63110	XXX-XXX-XXXX	XXX-XXX-XXXX
5	II Pediatric Level II	Deaconess Hospital	600 Mary St Evansville, Indiana 47747	XXX-XXX-XXXX	XXX-XXX-XXXX
	II Pediatric Level II	St Mary's Healthcare Services	3700 Washington Ave Evansville, Indiana 47750	XXX-XXX-XXXX	XXX-XXX-XXXX
6	I	Carle Foundation Hospital	611 W Park St Urbana, Illinois 61801	XXX-XXX-XXXX	XXX-XXX-XXXX
7	I	Advocate Christ Medical Center	4440 W 95th St Oak Lawn, Illinois 60453	XXX-XXX-XXXX	XXX-XXX-XXXX

EMS Region	DESIGNATED TRAUMA LEVEL	HOSPITAL	ADDRESS	PRIMARY CONTACT PHONE NUMBER (HOSPITAL INCIDENT COMMAND CENTER)	SECONDARY CONTACT PHONE NUMBER (EMERGENCY DEPARTMENT PHONE NUMBER)
	II	Morris Hospital	150 W High St Morris, Illinois 60450	XXX-XXX-XXXX	XXX-XXX-XXXX
	II	Presence St. Joseph Medical Center	333 N Madison St Joliet, Illinois 60435	XXX-XXX-XXXX	XXX-XXX-XXXX
	II	Presence St. Mary's Hospital	500 W Court St Kankakee, Illinois 60901	XXX-XXX-XXXX	XXX-XXX-XXXX
	II	Riverside Medical Center	350 N Wall St Kankakee, Illinois 60901	XXX-XXX-XXXX	XXX-XXX-XXXX
	II	Silver Cross Hospital	1900 Silver Cross Blvd New Lenox, Illinois 60451	XXX-XXX-XXXX	XXX-XXX-XXXX
8	I	Advocate Good Samaritan Hospital	3815 Highland Ave Downers Grove, Illinois 60515	XXX-XXX-XXXX	XXX-XXX-XXXX
	I	Loyola University Medical Center	2160 S First Ave Maywood, Illinois 60153	XXX-XXX-XXXX	XXX-XXX-XXXX
	II	AMITA Adventist Medical Center – Bolingbrook	500 Remington Blvd Bolingbrook, Illinois 60440	XXX-XXX-XXXX	XXX-XXX-XXXX
	II	AMITA Adventist Medical Center -Glen Oaks	701 Winthrop Ave Glendale Heights, Illinois 60139	XXX-XXX-XXXX	XXX-XXX-XXXX
	II	AMITA Adventist Medical Center – Hinsdale Hospital	120 N Oak St Hinsdale, Illinois 60521	XXX-XXX-XXXX	XXX-XXX-XXXX
	II	AMITA Adventist Medical Center – Lagrange Hospital	5101 S Willow Springs Rd LaGrange, Illinois 60525	XXX-XXX-XXXX	XXX-XXX-XXXX
	II	Edward Hospital	801 S Washington St Naperville, Illinois 60540	XXX-XXX-XXXX	XXX-XXX-XXXX
	II	Elmhurst Memorial Hospital	155 E Brush Hill Rd Elmhurst, Illinois 60126	XXX-XXX-XXXX	XXX-XXX-XXXX
	II	Gottlieb Hospital	801 W North Ave Melrose Park, Illinois 60160	XXX-XXX-XXXX	XXX-XXX-XXXX
	II	MacNeal Hospital	3249 S Oak Park Ave Berwyn, Illinois 60402	XXX-XXX-XXXX	XXX-XXX-XXXX

ATTACHMENT 16: Distributing Burn Patients to Non-Burn Hospitals

EMS Region	DESIGNATED TRAUMA LEVEL	HOSPITAL	ADDRESS	PRIMARY CONTACT PHONE NUMBER (HOSPITAL INCIDENT COMMAND CENTER)	SECONDARY CONTACT PHONE NUMBER (EMERGENCY DEPARTMENT PHONE NUMBER)
	II	Northwestern Central DuPage Hospital	25 N Winfield Rd Winfield, Illinois 60190	XXX-XXX-XXXX	XXX-XXX-XXXX
9	I	Advocate Lutheran General Hospital	1775 Dempster St Park Ridge, Illinois 60068	XXX-XXX-XXXX	XXX-XXX-XXXX
	II	Advocate Good Shepherd Hospital	450 W Highway 22 Barrington, Illinois 60010	XXX-XXX-XXXX	XXX-XXX-XXXX
	II	Advocate Sherman Hospital	1425 N Randall Rd Elgin, Illinois 60123	XXX-XXX-XXXX	XXX-XXX-XXXX
	II	AMITA Health Alexian Brothers Medical Center	800 Biesterfield Rd Elk Grove Village, Illinois 60007	XXX-XXX-XXXX	XXX-XXX-XXXX
	II	AMITA Health St. Alexius Medical Center	1555 N Barrington Rd Hoffman Estates, Illinois 60169	XXX-XXX-XXXX	XXX-XXX-XXXX
	II	Centegra Hospital – McHenry	4201 W Medical Center Dr McHenry, Illinois 60050	XXX-XXX-XXXX	XXX-XXX-XXXX
	II	Centegra Hospital – Woodstock	3701 Doty Rd Woodstock, Illinois 60098	XXX-XXX-XXXX	XXX-XXX-XXXX
	II	Northwest Community Hospital	800 W Central Rd Arlington Heights, Illinois 60005	XXX-XXX-XXXX	XXX-XXX-XXXX
	II	Northwestern Medicine Delnor Hospital –	300 Randall Rd Geneva, Illinois 60134	XXX-XXX-XXXX	XXX-XXX-XXXX
	II	Presence Mercy Medical Center	1325 N Highland Ave Aurora, Illinois 60506	XXX-XXX-XXXX	XXX-XXX-XXXX
	II	Presence St. Joseph Hospital	77 N Airlite St Elgin, Illinois 60123	XXX-XXX-XXXX	XXX-XXX-XXXX
	II	Rush-Copley Medical Center	2000 Ogden Ave Aurora, Illinois 60504	XXX-XXX-XXXX	XXX-XXX-XXXX
10	I	Advocate Condell Medical Center	801 S Milwaukee Ave Libertyville, Illinois 60048	XXX-XXX-XXXX	XXX-XXX-XXXX

EMS Region	DESIGNATED TRAUMA LEVEL	HOSPITAL	ADDRESS	PRIMARY CONTACT PHONE NUMBER (HOSPITAL INCIDENT COMMAND CENTER)	SECONDARY CONTACT PHONE NUMBER (EMERGENCY DEPARTMENT PHONE NUMBER)
	I	NorthShore Evanston Hospital	2650 Ridge Ave Evanston, Illinois 60201	XXX-XXX-XXXX	XXX-XXX-XXXX
	I	Presence St Francis Hospital	355 N Ridge Ave Evanston, Illinois 60202	XXX-XXX-XXXX	XXX-XXX-XXXX
	II	NorthShore Glenbrook Hospital	2100 Pfingsten Rd Glenview, Illinois 60026	XXX-XXX-XXXX	XXX-XXX-XXXX
	II	NorthShore Highland Park Hospital	777 Park Ave West Highland Park, Illinois 60035	XXX-XXX-XXXX	XXX-XXX-XXXX
	II	NorthShore Skokie Hospital	9600 Gross Point Rd Skokie, Illinois 60076	XXX-XXX-XXXX	XXX-XXX-XXXX
	II	Northwestern Lake Forest Hospital	660 N Westmoreland Rd Lake Forrest, Illinois 60045	XXX-XXX-XXXX	XXX-XXX-XXXX
	II	UHS St. Catherine Medical Center	9555 76th St Pleasant Prairie, WI 53158	XXX-XXX-XXXX	XXX-XXX-XXXX
	II	Vista Medical Center East	1324 N Sheridan Rd Waukegan, Illinois 60085	XXX-XXX-XXXX	XXX-XXX-XXXX
11	I	Advocate Illinois Masonic Medical Center	836 W Wellington Ave Chicago, Illinois 60657	XXX-XXX-XXXX	XXX-XXX-XXXX
	Pediatric Level I	Ann & Robert H. Lurie Children's Hospital of Chicago	255 E Chicago Ave Chicago, IL60611	XXX-XXX-XXXX	XXX-XXX-XXXX
	I Pediatric Level I	John H Stroger, Jr Hospital of Cook County	1969 W Ogden Chicago, IL 60612	XXX-XXX-XXXX	XXX-XXX-XXXX
	I Pediatric Level I	Mount Sinai Hospital	1500 S California Chicago, Illinois 60608	XXX-XXX-XXXX	XXX-XXX-XXXX
	I	Northwestern Memorial Hospital	251 E Huron St Chicago, IL 60611	XXX-XXX-XXXX	XXX-XXX-XXXX
	Pediatric Level I	University of Chicago Comer Children’s Hospital	5841 S Maryland Ave Chicago, IL 60637	XXX-XXX-XXXX	XXX-XXX-XXXX

ATTACHMENT 17: BURN PATIENT TRANSFER FORM

Purpose: Provide a method of communicating medical and treatment information during a disaster when burn patients are being transferred to another health care facility (e.g. hospital with burn capabilities)

Instructions: This form should be completed to the best of the provider's ability given the care that has been provided on every patient being transferred out to another health care facility. This form should be completed prior to transfer. The original form will accompany the patient while a copy of the form should remain with the patient's medical record at the transferring health care facility.

Note: All information within this form is confidential and should not be shared except with those assisting in the care of the patient.

Incident name		**Date** / /	**Time** :
Form completed by	**Title**		
Patient Name (Last, First)	**DOB** / /		**Sex** □ Male □ Female
Tracking Number (assigned by initial health care facility)	**Age** _____Years _____Months □ Estimated		
Family/Guardian_____ **Contact #**_____ **Notified:** YES NO			
Transferring health care facility **Unit at hospital** **Full address**	**Transferring physician**		
	Transferring health care facility telephone		
	Receiving physician		
	Receiving health care facility **Room #**		
Acuity Level □ Stable/Non-emergent □ Stable/Urgent □ Unstable/Emergent			

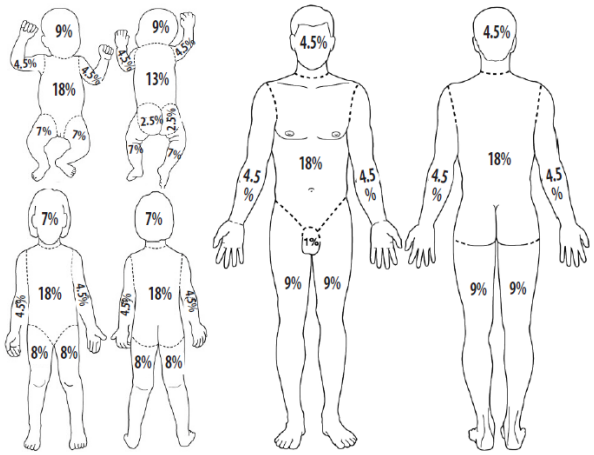
PATIENT HISTORY

Pre-burn weight _____kg □ actual □ estimated	**Allergies (list)** □ NKDA □ Unknown	**Home medications (list)** □ None □ Unknown □ See attached medication reconciliation form
Relevant medical/surgical history (list) □ See attached		

BURN INJURY HISTORY

Burn Injury Date	**Time of Injury**		**% Total Burn Surface Area (Complete burn diagram below to identify specific areas of injury)** % partial thickness _____ % full thickness _____ Circumferential truncal burn YES NO Circumferential extremity burn YES NO
Mechanism of Injury			
Burn Type		**Source**	
Flame			
Inhalation		Enclosed space / Open Air	
Scald			
Chemical			**Non-burn injuries**
Electrical			
Contact			**Non-burn wounds**
Radiation			

Burn Diagram



Area	≤1 y.o.	1-9 y.o.	10-17 y.o.	≥18 y.o.	Open	Healed
Head	19	13	11	7		
Neck	2	2	2	2		
Ant. Trunk	13	13	13	13		
Post. Trunk	13	13	13	13		
Right Buttock	2.5	2.5	2.5	2.5		
Left Buttock	2.5	2.5	2.5	2.5		
Genitalia	1	1	1	1		
Right Upper Arm	4	4	4	4		
Left Upper Arm	4	4	4	4		
Right Lower Arm	3	3	3	3		
Left Lower Arm	3	3	3	3		
Right Hand	2.5	2.5	2.5	2.5		
Left Hand	2.5	2.5	2.5	2.5		
Right Thigh	5.5	8	8.5	9.5		
Left Thigh	5.5	8	8.5	9.5		
Right Calf	5	5.5	6	7		
Left Calf	5	5.5	6	7		
Right Foot	3.5	3.5	3.5	3.5		
Left Foot	3.5	3.5	3.5	3.5		
Totals						

FORM CONTINUES ON PAGE 2

ATTACHMENT 17: BURN PATIENT TRANSFER FORM

MEDICAL MANAGMENT

Respiratory Status
Current FiO_2 _____ Current SpO_2 _____
Intubated YES NO
ETT/Trach tube size _____
Location at the teeth: _____
Ventilator settings _____
_____
Latest ABG_____
Respiratory treatments _____

Vital Signs
Time_____
HR
RR
BP
Temp

Intake
IV #1: Site_____
_____@_____mL/hr
IV #2: Site_____
_____@_____mL/hr
Other_____
Total IVF since injury _____mL
Total IVF in last 24 hours _____mL
Total IVF since admission _____mL

Procedures and Dressings
Current burn wound dressing _____
Date/time last burn wound eval _____
Date/time last burn dressing change _____
Escharotomies: YES NO Date/Time _____
Site(s)_____

Output
Urinary catheter YES NO
Urine (last 24 hours) _____mL
Urine (last 4 hours)_____ mL
NGT _____mL
Other _____

Current Medications
Tetanus vaccination given YES NO N/A
Antibiotics (name, date and time given)_____
_____
Other _____
_____

Pain Management

TRANSPORT NEEDS

Type of transport service needed □ BLS □ ALS □ Critical Care □ Ground □ Air □ Other_____

Name of transport provider used to transport patient:
_____
Phone number of transport provider: _____

Equipment needed for transport □ Oxygen □ Ventilator □ C-PAP □ Cardiac monitor □ IV pump □ Invasive monitoring □ Spine immobilization □ Restraints □ Isolette □ Car seat □ Other (list)_____

Notification (times) Family_____ SBCC_____ Receiving hospital: _____

OTHER NOTES

ATTACHMENT 18: ADULT BURN CARE GUIDELINES

Purpose: Provide guidance to practitioners caring for adult burn patients during a disaster.
Instructions: These guidelines should be used as a reference by non-burn hospital providers when caring for adult burn patients for extended periods of time when the annex is activated during a burn MCI. These guidelines should be used in conjunction with medical consultation from the State Burn Coordinating Center (SBCC).
Disclaimer: This guideline are not meant to be all inclusive, replace an existing policy and procedure at a health care facility or substitute for clinical judgment. These guidelines may be modified at the discretion of the health care provider.

96 Hour Care Guidelines for Adult Burn Patients if Transfer to a Hospital with Burn Capabilities is Not Feasible

Initial Patient Treatment

- Stop the burning process.
- Use universal precautions.
- Remove all clothing and jewelry.
- Prior to initiating care of the patient with wounds, it is critical that health care providers take measures to reduce their own risk of exposure to potentially infectious substances and/or chemical decontamination. Rinse liberally with water, according to protocol if suspected chemical exposure. Apply clean, dry dressing(s) initially to avoid hypothermia.
- Apply clean DRY sheet or bedding to prevent hypothermia.
- For the care of a burn patient with radiation exposure, see page 81.
- Consult the State Burn Coordinating Center (SBCC) for assistance with care of the acutely and critically ill patient, to individualize patient care, if patient does not improve and needs to be transferred and as needed for further support and consult.
- Palliative care/comfort care patients: During a burn MCI, resources may not be available to treat those with extensive burn injuries. There are sections within the following guidelines that provide guidance to providers in order to address their needs. Consult the SBCC for additional assistance from palliative care experts.

Primary Assessment, Monitoring, Interventions and Key Points

Assessment and Monitoring	Interventions	Key Points

Airway Maintenance with Cervical Spine Motion Restriction
• Assess throat and nares
• Signs of airway injury
  ○ Hypoxia
  ○ Facial burns
  ○ Carbonaceous sputum
  ○ Stridor
  ○ Hoarseness
  ○ Nasal singe
  ○ History of a closed space fire
	Airway Maintenance with Cervical Spine Motion Restriction
	• Chin lift/jaw thrust with C-spine motion restriction as needed.
	• Place an oral pharyngeal airway or endotracheal tube (ETT) in the unconscious patient.
	• Intubate early.
	• Secure ETT with ties passed around the head; do not use tape on facial burns since it will not adhere to burned tissue.
		Airway Maintenance with Cervical Spine Motion Restriction
		• Airway edema increases significantly after IV/IO fluids are started.
		• Stridor or noisy breath sounds indicate impending upper airway obstruction.
		• Prophylactic intubation is preferred because the ensuing edema obliterates landmarks needed for successful intubation. However, during a burn MCI, there is a need to consider resource availability (e.g. number of ventilators, number of trained staff to

ATTACHMENT 18: ADULT BURN CARE GUIDELINES

Assessment and Monitoring	Interventions	Key Points
	• Insert gastric tube on all intubated patients. • **Palliative care/comfort Care Patients**: Patients triaged as expectant or to receive palliative/comfort care only should not be intubated. Administer oxygen to aid comfort and prevent air hunger. Also consider pain management. See pages 76-77 for more guidelines	manage ventilators) • It is critical that the ETT is secured well. An ETT that becomes dislodged may be impossible to replace due to the edema of the upper airway.
<u>Breathing and Ventilation</u> • Assess for appropriate rate and depth of respirations with adequate air exchange. • Monitor pulse oximetry while checking Carbon Monoxide (CO) level (as needed). • If circumferential torso burns, monitor chest expansion closely. • Obtain Arterial Blood Gas (ABG). • Obtain Carboxyhemoglobin (COHb) level if suspected inhalation injury.	<u>Breathing and Ventilation</u> • 100%, high flow oxygen using a non-rebreather mask or ETT; wean as appropriate. • Mechanically ventilate as needed. Ventilator settings are not different for burn patients compared to other patients. • Elevate head of bed (HOB), if not contraindicated to decrease facial edema • Consult with SBCC to determine if escharotomy is indicated and to receive guidance on performing an escharotomy.	<u>Breathing and Ventilation</u> • CO levels decrease by half (½) every 40 minutes while on 100% FiO_2. CO level goal is <10%. • An escharotomy is an incision performed longitudinally through burned tissue down to subcutaneous tissue over the entire involved area of full thickness circumferential (or nearly circumferential burn) that is causing constriction and loss of peripheral perfusion or airway constriction. A chest escharotomy may be indicated in circumferential or full thickness chest burns due to location or depth of burn in the trunk area, which may interfere with ventilation.
<u>Circulation with Hemorrhage Control</u> • Continuous cardiac monitoring as needed. • Control any signs of hemorrhage.	<u>Circulation with Hemorrhage Control</u> • Two large bore peripheral IVs in non-burned, upper extremities (secure well). • If unable to secure peripheral IV in non-burned extremity, burned extremity can be used if necessary; suture IV in place. • Initiate IVF bolus with Lactated Ringers (LR). • If unable to establish a peripheral IV, place	<u>Circulation with Hemorrhage Control</u> • Cardiac monitoring may be needed, if there is an electrical injury, concurrent trauma or cardiac issues. • Dysrhythmias may be the result of an electrical injury. • To secure an IV on burned skin (tape will not stick), consider suturing in place or using self-adhesive (e.g. Coban) or other type of wrap. Self-adhesive or other wraps should be applied loosely to prevent skin

ATTACHMENT 18: ADULT BURN CARE GUIDELINES

Assessment and Monitoring	Interventions	Key Points
	an intraosseus (IO). IO access can be through burned skin. • Initial IVF with Lactated Ringers (LR) ○ ≥ 14 y/o= 500 mL LR/hour	breakdown. • **Palliative care/comfort care patients:** IVs should be started for the administration of medications for pain and anxiety. Do not administer large volumes of fluid. Excessive fluid will result in decreased circulation and increased pain due to edema.

<u>Disability</u>
• Neurologic checks every 4 hours and PRN
  ○ Determine level of consciousness
  ○ Obtain Glasgow Coma Scale
  ○ Consider using "AVPU,"
  ▪ A: Alert
  ▪ V: Responds to verbal stimuli
  ▪ P: Responds to painful stimuli
  ▪ U: Unresponsive
	<u>Disability</u>
	Treat cause of altered neurological status as indicated.
		<u>Disability</u>
		• If altered neurological status, consider the following:
		  ○ Associated injuries
		  ○ CO poisoning
		  ○ Substance abuse
		  ○ Hypoxia
		  ○ Hypoglycemia
		  ○ Pre-existing medical condition

<u>Exposure</u>
• Monitor temperature.
	<u>Exposure</u>
	• Remove all clothing and jewelry
	• Initially place a clean, dry sheet over the wounds until a thorough cleaning is done.
	• Keep patient and environment warm.
	  ○ Keep patient covered
	  ○ Cover the patient's head
	  ○ Warm the room
	  ○ Warm the IV/IO fluids
	  ○ External patient warming devices
		<u>Exposure</u>
		• Localized hypothermia causes vasoconstriction to damaged area reducing blood flow and tissue oxygenation and may deepen the injury. Systemic hypothermia (core temp less than 95° F/35° C) induces peripheral vasoconstriction that may increase the depth of the burn and interfere with clotting mechanisms and respiration in addition to causing cardiac arrhythmias.
		• Use portable radiant heaters with caution

<u>Secondary Assessment, Monitoring, Interventions and Key Points</u>

Assessment and Monitoring	Interventions and Key Points
<u>History</u> • Obtain circumstances of injury. • Obtain medical history. Consider using "AMPLET."	<u>History</u> • Obtain history from patient early before intubation if possible. Obtain contact information for family as well.

ATTACHMENT 18: ADULT BURN CARE GUIDELINES

Assessment and Monitoring	Interventions and Key Points
○ Allergies, Medications, Previous illness/history, Last meal/fluid intake, Events related to injury, Tetanus vaccination	
<u>Complete Physical Exam</u> • Head to toe exam • Vital signs: (Perform as indicated in health care facility policy. May need to perform more frequently if patient is unstable). ○ Heart rate (HR) ○ Blood pressure (BP) ○ Respiratory rate (RR) ○ Temperature ○ Pulse oximetry ○ Capillary refill ○ Skin color of unburned skin ○ Imperative to obtain weight on patient ▪ If possible obtain weight before initiating IVF resuscitation • Determine extent/size of burn by calculating the Total Burn Surface Area (TBSA) using: ○ Rule of Nines or Rule of the Palm (See page 80 for printable version) ○ Lund-Browder chart (See page 79 for printable version) • Determine the depth of the burn (See page 78 for more information) ○ *Superficial (1st degree)* ▪ Involves the epidermis ▪ Appearance: Red (e.g., sunburn) ▪ Do not include when calculating % TBSA ○ *Partial thickness (2nd degree)* ▪ Involves the entire epidermis and a variable portion of the dermis. ▪ Appearance: red, blistered and edematous. ○ *Full thickness (3rd degree)*	<u>Complete Physical Exam</u> • Due to increased catecholamines and hypermetabolism associated with burn injures, the HR will be increased. Relative tachycardia is normal for burn patients (100-120 BPM). Sustained tachycardia may indicate hypovolemia, inadequate oxygenation, unrelieved pain or anxiety • May need to use doppler to obtain blood pressure. Oral rehydration can be used in the following patients: ○ Patient is not intubated ○ Injury is not an electrical injury ○ Awake and alert with % TBSA < 20% ○ Monitor quality and quantity of urine output on patient's receiving oral rehydration. ○ Contact the SBCC for assistance with oral rehydration . • IV/IO fluids burn resuscitation-Use Lactated Ringers: ○ When supplies of LR are depleted, 0.9 NS and 0.45 NS or colloids can be used for fluid resuscitation. Do not use fluid containing glucose. ○ 2 mL x wt (kg) x % TBSA = total for first 24 hrs post burn. ○ For electrical burns: 4 mL x wt (kg) x % TBSA = total for first 24 hrs post burn. ○ Administer half of the above amount in first 8 hours post burn. ○ Administer remaining amount over next 16 hours post burn. • The above calculation is a starting point for fluid resuscitation. IVF rate should be titrated to maintain urine output: ○ 0.5 mL/kg (~30-50 mL/hr) • Tetanus prophylaxis unless received within last 5 years. • Place a soft feeding tube for all intubated patients. Feedings should be initiated within 6 hours of injury. • The goal in the early stages of burn resuscitation should be to maintain the

ATTACHMENT 18: ADULT BURN CARE GUIDELINES

Assessment and Monitoring	Interventions and Key Points
▪ Involves the destruction of the entire epidermis and dermis. ▪ Appearance: white, brown, dry, leathery with possible coagulated vessels. • If camera is available, take pictures of initial burn injuries to document progression of burn injury. • Labs on admission and every day as indicated by medical condition: o Electrolyte panel o Complete blood count (CBC) o ECG for electrical injury or cardiac history o ABG with COHb o Cardiac panel for electrical injury • CXR if intubated, inhalation injury suspected or underlying pulmonary condition. • Monitor for the following signs and symptoms in full thickness, circumferential burn injuries that may indicate a circulation deficit and possible need for escharotomy: (6 P's) o Pallor or cyanosis of distal unburned skin on a limb o Pain o Pulselessness o Paralysis o Paresthesia o Poikilothermia o Inability to ventilate in patients with deep circumferential burns of the chest	individual's pre-event BP. • If signs of circulation deficit are present, contact the SBCC. • Eyes: o Remove contact lens prior to eyelid swelling, if facial involvement. o Fluorescein should be used to identify corneal injury. o If eye involvement or facial burns, consider consulting an ophthalmologist. • Consult with SBCC to determine if escharotomy is indicated and to receive guidance on performing an escharotomy. • Finger escharotomies are rarely indicated.
<u>Comfort</u> • Frequent pain/sedation assessment o A minimum of every 4 hours o Before and after pain/sedation medication given	<u>Comfort</u> • Emotional support and education is essential. • IV/IO analgesia is preferred route during initial post injury period. • Large amounts of IV/IO analgesic may be required to attain initial pain control (e.g., Morphine 40-60 mg). o Administer opioids in frequent (every 5 minutes) small to moderate

ATTACHMENT 18: ADULT BURN CARE GUIDELINES

Assessment and Monitoring	Interventions and Key Points
	doses until pain is controlled. ▪ Narcotic/analgesic PO/IV/IO • Morphine, Dilaudid, fentanyl • Oxycodone/acetaminophen, hydrocodone/acetaminophen, oxycodone, methadone PO • Consider use of non-pharmacological techniques. • Consider anti-anxiety medication in addition to pain medication. o Lorazepam (Ativan) PO/IV/IO o Midazolam (Versed) IV/IO/IN • Consider sedation for procedures and if intubated: o Lorazepam (Ativan) o Midazolam (Versed)
<u>Wound Care</u> • Maintain temperature of patient since they are prone to hypothermia • Assess the wound and monitor for: o Change in wound appearance o Change in size of wound o Signs or symptoms of infection • Describe what you see: o Color (e.g. white, leathery, or pink, moist) o Sensation (distinguish between pain and sensation) o Temperature o Swelling o Cellulitis (redness around the wound) o Odor (foul smelling, sweet smelling, etc.) o Drainage (amount, type) • Compartment syndrome o Can have in non-burned limbs and abdomen • Check of the circulation of an extremity before and after wound care	<u>Wound Care</u> • Pre-medicate patients for pain and anxiety before wound care. • In a mass casualty disaster situation wound care for patient with a >20% TBSA burn can be performed once per day. • Contraindications for silver sulfadiazine (Silvadene): o Patients with a sulfa allergy o During pregnancy • Wash wounds with soap and warm tap water using a wash cloth o Remove water by patting dry • Shave daily for burned scalps and faces • Perform wound care every day if using: o Silver sulfadiazine (Silvadene) cream o Bacitracin • Debride ALL blisters except for: o Intact blisters on hands and feet, unless it is impeding range of motion to the joints. o Weeping blister(s) • Ear wound care: o Ears are poorly vascularized and at risk for chondritis.

ATTACHMENT 18: ADULT BURN CARE GUIDELINES

Assessment and Monitoring	Interventions and Key Points

	• How to apply silver sulfadiazine (Silvadene) cream:
	  ○ Apply thin layer enough so that the wound cannot be seen through the cream.
	  ○ The layer of sulfadiazine should be thick enough to prevent the wound from drying out prior to the next dressing change.
	  ○ Cover with a dressing; the purpose of a dressing is to keep the cream from rubbing off before the next dressing change.
	• How to apply silver impregnated antimicrobial dressings (e.g., Acticoat^{R}, Mepilex):
	  ○ Apply a single layer of the dressing moistened with water over burn wounds so that all areas are covered.
	  ○ Water should be used to keep the dressing and overlying gauze moist to maintain the dressing's antimicrobial activity. *(DO NOT use saline because it deactivates the silver's antimicrobial ability)*.
	  ○ Should be held in place with water-moistened gauze dressing.
	  ○ Dressing does not need to be changed for 7 days.
	  ○ The overlying gauze can be changed as necessary.
	  ○ If signs of infection appear, remove dressing to assess wound.
	  ○ Record the date of the application.
	• Wrap fingers separately, if burned.
	• Place silver sulfadiazine (Silvadene) coated gauze between the toes.
	• For extensive and severe burns to the face:
	  ○ Apply Bacitracin ointment around the eyes and mouth to avoid cream from draining into them.
	  ○ Can use ophthalmic ointment around eyes.
	  ○ Silver sulfadiazine (Silvadene) can be used on the face
	• For moderate facial burns, Bacitracin or other antibiotic ointment can be used without a dressing.
	• Genital/Perineal Burns
	  ○ Urinary catheter may be indicated for genitalia or perineal burns. Evaluate each patient individually to determine if needed.
	  ○ Apply lubricated gauze to labia and in the foreskin to prevent adhesions

ATTACHMENT 18: ADULT BURN CARE GUIDELINES

Assessment and Monitoring	Interventions and Key Points
	and decrease risk of infection in this area of high contamination. • Elevate burned extremities above the level of the heart

Ongoing Assessment, Monitoring, Interventions and Key Points

Assessment and Monitoring	Interventions
Airway and Breathing • Obtain chest X-ray if intubated, inhalation injury suspected or underlying pulmonary condition. • Chest X-ray will usually be clear on admit. If inhalation injury is present the X-ray will show infiltrates around the second day correlating with a deteriorating oxygen status. • Frequent suctioning is necessary to prevent occlusion of the airway and endotracheal tube. Anyone with an inhalation injury is subject to increased respiratory secretions and may have a large amount of carbonaceous debris in the respiratory tract. • Airway edema peaks at 36 hours post burn • Weaning from the ventilator and extubation: o CO level should be normalized (< 10%) for at least 6 hours o There is an increased risk of needing to re-intubate inhalation injury patients so maintain intubation equipment at bedside after extubation o Don't extubate patient unless there is a leak around the ETT cuff	Airway and Breathing • Supportive therapy and O_2; wean as appropriate. • HOB should be elevated 30˚ to minimize facial and airway edema, unless contraindicated. o Use reverse Trendelenburg for patients with C-spine motion restriction requirements. • Suction airway frequently. • **Inhalation Injuries:** o Treatment for inhalation injury is supportive care and includes: ▪ Intubation as indicated ▪ Provide adequate sedation to prevent dislodgement of ETT ▪ Frequent suctioning ▪ Positive End Expiratory Pressure (PEEP) may improve ventilation o Secure ETT with ties instead of tape since tape will not adhere to burned tissue. o Mark ETT at fixed position (teeth or gums not lips which may have swelling).
Outputs of Resuscitation • Monitor Mean Arterial Blood Pressure o Goal for Mean Arterial Blood Pressure is >60 mmHg • Monitor hourly urine output: o Goal: 0.5 mL/kg/hr (≈30-50 mL/hour) o Goal for electrical burns: 1 mL/kg/hr • Monitor for myoglobin/pigment in urine (burgundy color)	Outputs of Resuscitation • Insert arterial line • Insert urinary catheter • If urine output is < goal ↑ fluids by 1/3. o Example: u/o = 20 mL/hr, fluid rate at 250 mL/hr, ↑ to 330 mL/hr • If urine output is > goal ↓rate of infusion by 1/3 o Example: u/o = 100 mL/hr fluid rate at 250 mL/hr, ↓to 167 mL/hr

ATTACHMENT 18: ADULT BURN CARE GUIDELINES

Assessment and Monitoring	Interventions

• Additional resuscitation fluid needs can occur with:
  ○ Very deep burns
  ○ Inhalation injury
  ○ Associated injuries
  ○ Electrical injury
  ○ Delayed resuscitation
  ○ Prior dehydration
  ○ Alcohol or drug dependence
• The elderly and patients with preexisting cardiac disease are particularly sensitive to fluid management.
• Diuretics are not indicated in myoglobin in the urine.
• May take > 24 hours to see signs of adequate resuscitation:
  ○ Normalization of blood pH
  ○ Improved peripheral circulation
  ○ Clearing sensorium (more alert)
  ○ Stable BP
If IVF requirements are still high after 24 hours of crystalloids, contact the SBCC for medical consultation.
	• Upon completion of the resuscitation phase (typically 24 hrs post burn):
	  ○ ↓ hourly fluid volume by 10% per hour to a maintenance fluid with D5 0.45 NS with 20 mEq KCL/L
	  ○ Check serum sodium and potassium on day 2 post burn
	• Myoglobin in urine:
	  ○ Maintain urine output:
	  ▪ 100 mL/hour
	  ○ Increase fluid rate (LR)
	• Oliguria or anuria requires mostly due to inadequate fluid resuscitation and requires more rapid fluid administration. **Diuretics are contraindicated!**
	• Treatments for hypotension:
	  ○ Albumin human 5% injection (consult SBCC before using)
	  ○ Vasopressors initiated when MAP is low despite adequate fluid resuscitation
	  ▪ Use institution specific dosing ranges

<u>Circulation</u>
• Perform pulse checks (CMS) every 1 hour, if there are circumferential burns on extremities.
  ○ Monitor pulses by palpation or doppler exam
  ▪ Decreased sensation
  ▪ Severe deep tissue pain
  ▪ Diminished distal pulses
  ▪ Capillary refill > 5 sec
• After 24-48 hours decrease frequency of pulse checks to every 2 hours if stable.
	<u>Circulation</u>
	• Elevate burned extremities on pillows or blankets to improve circulation and minimize edema.
	• Circumferential chest injuries may become life threatening; an escharotomy may be necessary.
	• Verify that pulselessness is not due to profound hypotension.
	• Scrotal swelling, though often significant, does not require specific treatment.

<u>Body Temperature</u> Perform temperature checks, based on health care facility protocol.	<u>Body Temperature</u> • Keep patient normo-thermic, especially during wound care. • Keep patient covered. When supplies of blankets are depleted, patients can be

ATTACHMENT 18: ADULT BURN CARE GUIDELINES

<table>
<tr><th>Assessment and Monitoring</th><th>Interventions</th></tr>
<tr><td>• If unstable or significant burn, hourly vital signs may be indicated.</td><td>wrapped in plastic wrap or aluminum foil for insulation and warmth.
• Warm the room.
• Warm IV/IO fluid, if possible, especially if patient is very hypothermic</td></tr>
<tr><td colspan="2"><u>Other Pharmaceutical Considerations</u></td></tr>
<tr><td>• Stress ulcer prophylaxis
○ Begin feedings within 6 hours of injury
○ Start on prophylaxis medications if intubated (based on institutional preference, hospital formulary and availability
• Anti-emetics
○ Use cautiously (enteral feeding intolerance can be a sign of sepsis in burn patients)
○ Ondansetron (Zofran®)
○ Metoclopramide (Reglan®)
• Itching
○ Diphenhydramine (Benadryl®)
○ Hydroxyxine (Atarax®)
• Vitamin Supplements
○ Start vitamins after feedings (via tube or PO) are initiated
○ Multivitamins
○ Ascorbic acid
○ Zinc sulfate
○ Glutamine (if available and on formulary)</td><td>• Venous thromboembolism prophylaxis
○ Patients with burn injuries have high risk of developing venous thromboembolism- especially when lower extremities are burned
▪ Pharmacoprophylaxis:
• Patients <u>with</u> burn to lower extremities:
○ Consider higher dose of enoxaparin (Lovenox®)
○ Enoxaparin (Lovenox®) 30 mg subcutaneously every 12 hours
• Patients <u>without</u> burns to lower extremity:
○ Enoxaparin (Lovenox®) 40 mg subcutaneously every 24 hours
○ Heparin 5000 units subcutaneously every 8 hours
• Patients with renal dysfunction or as an alternative to enoxaparin
○ Heparin 5000 units subcutaneously every 8 hours
○ Avoid enoxaparin (Lovenox®)
▪ Mechanical prophylaxis
• For all patients without contraindication (e.g. burn to lower extremity)</td></tr>
<tr><td><u>Nutrition</u>
• Obtain dry weight on admission
• Nutritional plan should start < 6 hours post injury
• Increased need for protein, calories, vitamins and minerals for wound healing
• Adequate intake is more important than route of intake
• TPN is rarely used. Oral feedings (via tube or PO) provides</td><td><u>Nutrition</u>
• Consult hospital dietitian to adjust nutritional plan based on lab result trends (CRP, Prealbumin, albumin & transferrin)
• Conduct daily calorie counts
• Daily calorie needs based on % TBSA, weight and age:
○ < 10% TBSA: 30 kcal/kg/day
○ 10-30% TBSA: 35 kcal/kg/day</td></tr>
</table>

ATTACHMENT 18: ADULT BURN CARE GUIDELINES

Assessment and Monitoring	Interventions

most benefit for burn patients.
• Indications for feeding tube:
  ○ Intubated
  ○ >20% TBSA
  ○ Unable to maintain caloric needs via PO
• Indications for post pyloric feeding tube:
  ○ Conscious sedation
  ○ Twice daily wound care
  ○ Frequent operative interventions
  ○ Intolerance of gastric feeding (nausea, vomiting, increased gastric residuals)
• See Nutritional Algorithm for Adult Burn Patients on page 87 for initial infusion rates, titrating feeding rates and residual check information
	○ > 30% TBSA: 40 kcal/kg/day
	• Protein requirements: 1.5-2.5 g protein/kg/day
	• Regular high calorie, high protein diet, if able to take PO.
	  ○ If unable to maintain adequate caloric requirements, initiate tube feedings.
	• No free water drinks (plain water) if taking PO, only high calorie liquids.
	• Soft feeding tubes are preferred over hard salem sump nasogastric tube.
	• Ensure stool softeners are ordered to prevent constipation due to pain medications.
	• Titrating patient off tube feedings to PO
	  ○ Switch to night feedings first
	  ○ If eating during the day and taking in enough calories, can progress to PO feedings only
	  ○ Titrating might be done in acute rehab setting and not in hospital setting

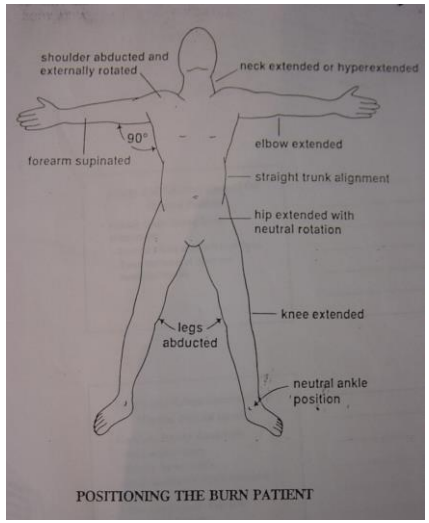
<table>
<tr><td colspan="2"><u>Infection Control</u>
• Utilize universal precautions
• If wounds are exposed:
  ○ Apply gown, mask and gloves to protect patient.
• No systemic antibiotics are required for the burn injuries.</td></tr>
<tr><td colspan="2"><u>Reunification</u>
During a large scale disaster, family members may become separated. It is crucial that staff attempt to reunify patients with their family. Community partners, such as the American Red Cross and National Center for Missing and Exploited Children, can assist with this process. The reunification process begins with EMS at the scene and, if possible, trying to keep known family members together when making transport decision. The Patient Identification Tracking Form (Attachment 12 in Burn Surge Annex) should be utilized for <u>all</u> patients to assist with the reunification process.</td></tr>
<tr><td><u>Splinting, Positioning and Mobility</u>
• In a disaster physical and occupational therapists may splint patients in functional positions and help with dressings.</td><td><u>Splinting, Positioning and Mobility</u>
• Obtain Physical Therapy /Occupational Therapy consult
• Early mobilization of patients
• HOB elevated at all times</td></tr>
</table>

• Rehabilitation (splinting, positioning and mobility) should be initiated early on in care of patient
• Check circulation status of extremities before and after positioning and splinting
• Monitor for pressure areas under splints
	• Elevate burned extremities above the level of the heart
	• Positioning:
	  ○ Degree of functioning preserved depends on early intervention and prevention of further tissue damage
	  ○ Designed to:
	  ▪ Minimize edema formation
	  ▪ Prevent tissue destruction
	  ▪ Maintain soft tissue in an elongated state to facilitate optimal functional recovery
	  ○ Use whatever tools are available to assist (e.g., pillows, towels, splints, bedside tables, wedges).
	• Neck burns
	  ○ Maintain the head in a neutral position
	  ○ No pillows or blankets under the head flexing the neck forward
	• Axilla burns
	  ○ Keep arms extended to decrease contractures
	• Ear burns
	  ○ No external pressure should be applied
	  ○ No pillows or blankets under the head
	• Out of bed (OOB) - If legs are burned, apply ace wraps when OOB
	• Encourage active range of motion hourly when awake
	• Encourage activities of daily living
	• Splinting:
	  ○ Use either ace/elastic wraps, gauze rolls/wraps, strappings with post-mold material (e.g., thermoplastic-perforated), or whatever is available
	  ○ Wearing schedule:
	  ▪ 24 hours/day except for dressing changes and range of motion exercises
	  ▪ At night only for compliant patients who are able to perform exercises independently
	  ▪ Post wearing schedule at patient's bedside

ATTACHMENT 18: ADULT BURN CARE GUIDELINES

Proper Positioning of Burn Patients

Area Involved	Contracture Predisposition	Contracture Preventing Position
Anterior neck	Flexion	Extension, no pillows
Anterior axilla	Shoulder adduction	90° abduction, neutral rotation
Posterior axilla	Shoulder extension	Shoulder flexion
Elbow/Forearm	Flexion/pronation	Elbows extended, forearm supinated
Wrists	Flexion	15°–20° extension
Hands:		
MCPs	Hyperextension	70°–90° flexion
IPs	Flexion	full-extension
Palmar Burn	Finger flexion, thumb opposition	All joints full extension, thumb radially abducted
Chest	Lateral/anterior flexion	Straight, no lateral or anterior flexion
Hips	Flexion, adduction, external rotation	Extension, 10° abduction, neutral rotation
Knees	Flexion	Extension
Ankles	Plantar flexion	90° dorsiflexion



Psychosocial

- Address the psycho-social needs of burn patients
  - Immediate needs (pain, fear of unknown, similar to any trauma patient)
  - Long term needs (more ongoing, can need support for years)
- Treatment therapies may trigger traumatic response
- Explain any procedures
- Involve patient and family
- Consider social worker consultation
- Offer spiritual care
- Consider consulting child life specialists to assist with coping of child visitors of patient (as applicable and available).

ATTACHMENT 18: ADULT BURN CARE GUIDELINES

Palliative Care/Comfort Care

During disasters, patients with extensive burn injuries may be triaged as Expectant based on the Burn Triage Guidelines.
Patient's triaged as Expectant still need palliative care/comfort care provided.
See the following page for additional information

ATTACHMENT 18: ADULT BURN CARE GUIDELINES

PALLIATIVE CARE COMPONENTS DURING DISASTER MANAGEMENT	
PATHWAY COMPONENT	**CONSIDERATIONS**
Assess the situation	Health of the patient Family dynamic if present
Identify key players	Patient needs Family and friends needs Physician needs Nurses needs
Consider the big picture of the key players	Staff Concerns and any distress of key players Psychological Symptoms of any key players Distress Physical Symptoms of the patient Pain Dyspnea Existential and Spiritual Symptoms of any key players Examples: o Last rites from a priest with Catholic backgrounds o Imam being available for Islamic backgrounds o Hindu and Buddhists have their own beliefs and requests at the end of life. Some request the patient being put on the floor, we never do this put we do lower the bed all the way to the floor. Legal and Ethical Aspects of Care Any member of the key players uncomfortable with end of life pathways Cultural Aspects of Care Examples: o Family requests for positioning of patient o Turing the bed toward specific directions if requested o Having LED candles available if family requests candles around the body End of Life Logistics Find a location that is accessible for family and friends
Communication	Set expectations and maintain communication
Develop and implement plan	Develop Plan/Manage Death: Implement postmortem logistics Pronouncing death Bereavement Staff debriefing/support
Manage pain, dyspnea, and agitation at the end of life	Family and nursing input is essential Don't forget that using opioids with the intent to control symptoms at the end of life is ethically appropriate Assess: • Distress • Pain: grimace, tachycardia, verbal cues • Agitation: writhing, sweating • Dyspnea: retractions, flaring, tachypnea Un-intubated patients: • Pain or dyspnea: Intermittent IV dosing preferred: Morphine and hydromorphone preferred o Reassess every 10 minute; repeat dose if needed Agitation: Benzodiazepines preferred: Lorazepam and haloperidol preferred Intubated patients: • Pain: Continuous IV infusions preferred: Morphine, fentanyl, and hydromorphone preferred • Agitation: Continuous IV infusions preferred: Midazolam and lorazepam preferred • Increase the dosing every ten minutes • If distress is present, bolus the mediation by one hour equivalent and increase infusion by 25 to 100%. Write orders allowing for titration

ATTACHMENT 18: ADULT BURN CARE GUIDELINES

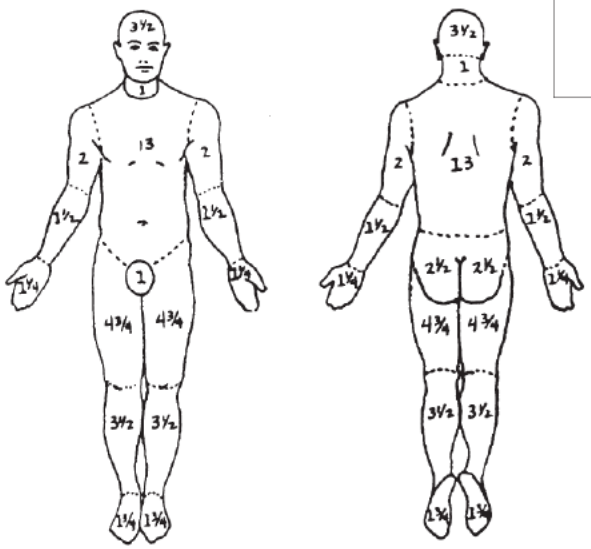
Assess Degree of Injury

	APPEARANCE	SURFACE	SENSATION	TIME TO HEALING
1st degree/superficial	Pink or red	Dry	Painful	4-5 days
2nd degree/superficial partial thickness	Pink, clear blisters	Moist, weeping	Painful	14–21 days
2nd degree/deep partial thickness	Pink, hemorrhagic blisters, red	Moist	Painful	Weeks, may progress to 3rd degree and require graft, may lead to contractures
3rd degree/full thickness	White, brown, charred	Dry, waxy, leathery	Painless	Requires excision, high risk for infection/fluid loss
4th degree (tendon, nerve, muscle, bone and/or deep fascia involvement)	Brown, charred	Dry	Painless	Requires excision, high risk for infection/fluid loss

ATTACHMENT 18: ADULT BURN CARE GUIDELINES

Lund & Browder Chart

BURN DIAGRAM, ESTIMATE
(Lund & Browder)



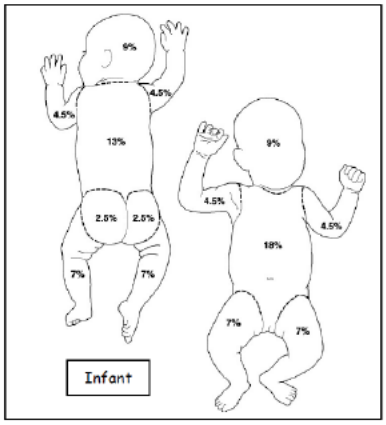
	AGE						BURN ASSESSMENT	
AREA	**infant**	**1-4**	**5-9**	**10-14**	**15**	**adult**	PARTIAL THICKNESS	FULL THICKNESS
head	19	17	13	11	9	7		
neck	2	2	2	2	2	2		
ant. trunk	13	13	13	13	13	13		
post. trunk	13	13	13	13	13	13		
r. buttock	2 1/2	2 1/2	2 1/2	2 1/2	2 1/2	2 1/2		
l. buttock	2 1/2	2 1/2	2 1/2	2 1/2	2 1/2	2 1/2		
genitalia	1	1	1	1	1	1		
r. u. arm	4	4	4	4	4	4		
l. u. arm	4	4	4	4	4	4		
r. l. arm	3	3	3	3	3	3		
l. l. arm	3	3	3	3	3	3		
r. hand	2 1/2	2 1/2	2 1/2	2 1/2	2 1/2	2 1/2		
l. hand	2 1/2	2 1/2	2 1/2	2 1/2	2 1/2	2 1/2		
r. thigh	5 1/2	6 1/2	8	8 1/2	9	9 1/2		
l. thigh	5 1/2	6 1/2	8	8 1/2	9	9 1/2		
r. leg	5	5	5 1/2	6	6 1/2	7		
l. leg	5	5	5 1/2	6	6 1/2	7		
r. foot	3 1/2	3 1/2	3 1/2	3 1/2	3 1/2	3 1/2		
l. foot	3 1/2	3 1/2	3 1/2	3 1/2	3 1/2	3 1/2		
						TOTAL:		

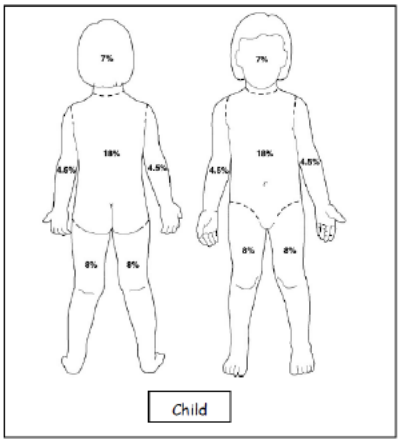
BURN ASSESSMENT: Date _____ Time _____ Signature _____

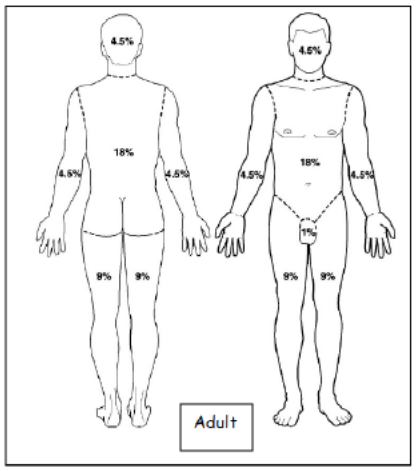
ATTACHMENT 18: ADULT BURN CARE GUIDELINES

Rule of 9's Charts:

BURN DIAGRAM ESTIMATE
(Rule of 9's: Estimate of TBSA – Total Burn Surface Area)







Area	Infant	Child	Adult	Burn Assessment	
				Partial thickness	Full thickness
Head	18	14	9		
Chest (Ant. torso)	18	18	18		
Back (Post. Torso) & buttocks	13 (back) 5 (buttocks)	18	18		
Rt. arm & hand	9	9	9		
Lt. arm & hand	9	9	9		
Rt. Leg & foot (anterior)	7	8	9		
Lt. Leg & foot (anterior)	7	8	9		
Rt. Leg & foot (anterior)	7	8	9		
Rt. Leg & foot (anterior)	7	8	9		
Perineum	(include with chest)	(include with chest)	1		

Bolded areas = nine or multiple of nine

Burn Assessment Date_____ Time _____ Signature_____

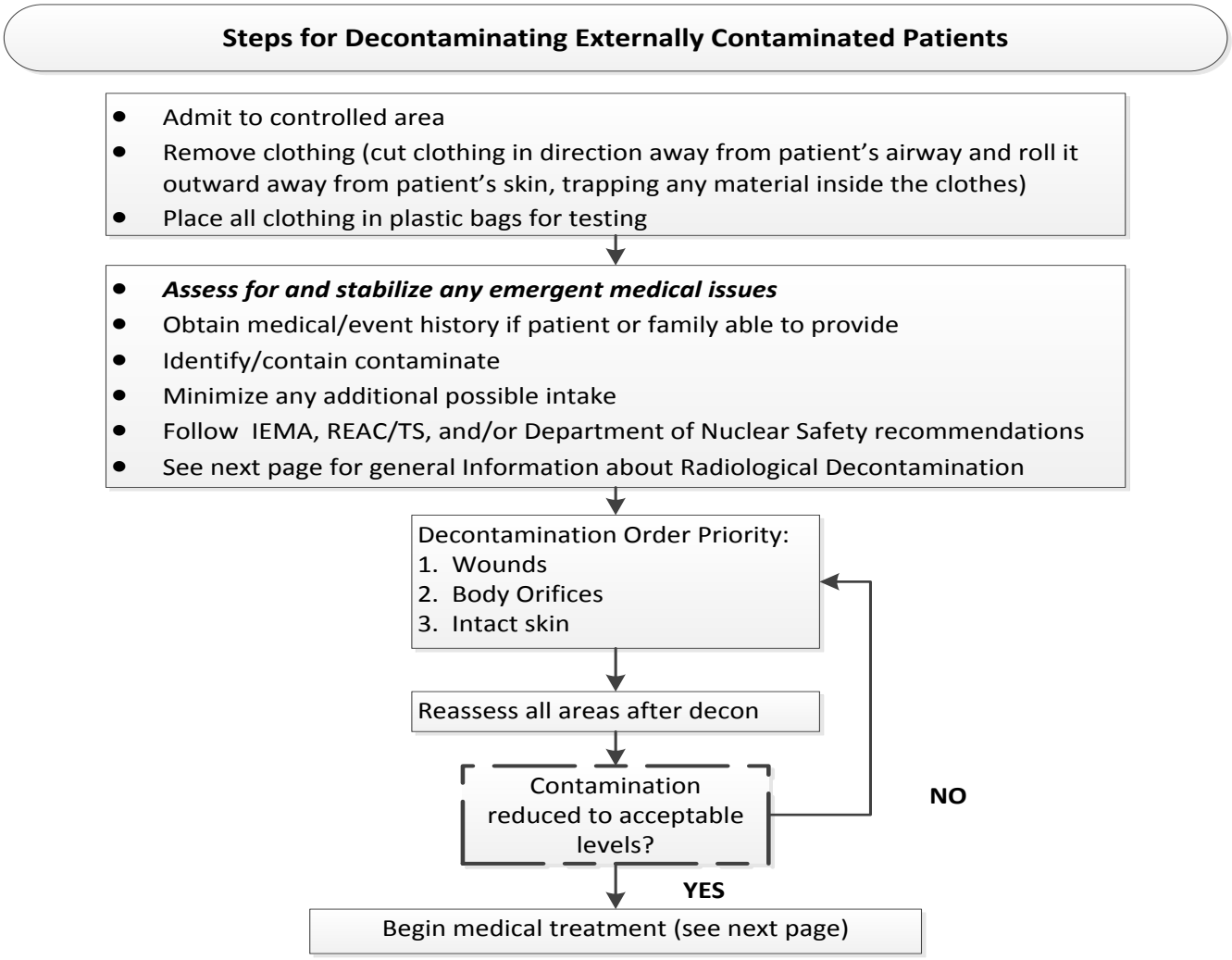
ATTACHMENT 18: ADULT BURN CARE GUIDELINES

Management of Burn Patients with Radiation Exposure

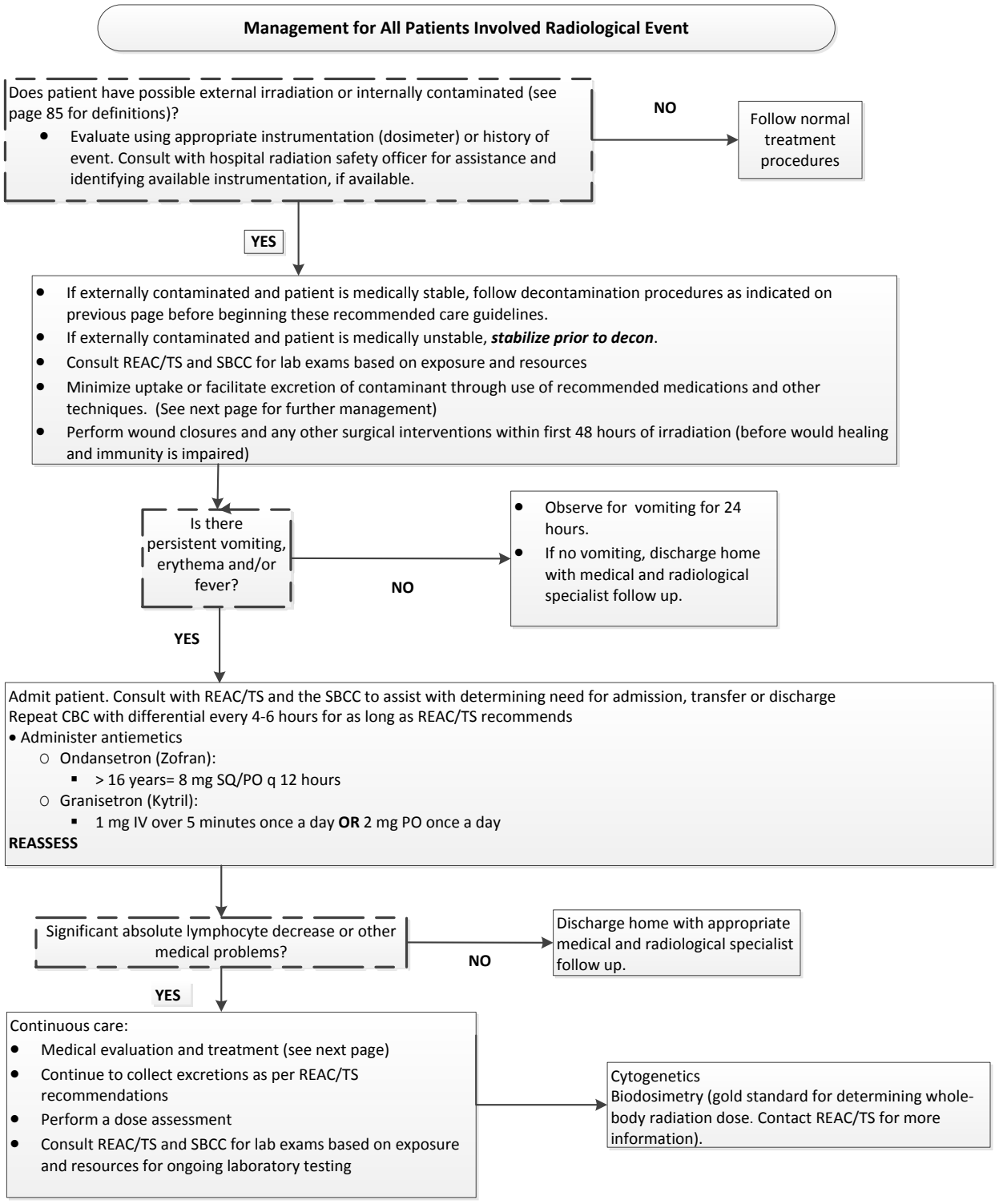
Initial Management of All Patients Involved in Radiological Event

- Determine if decontamination is needed due to external contamination (See pages 82, 83 and 86 for information specific to decon)
- Stabilize ABCs (Airway, Breathing, Circulation)
- Immobilize spine as indicated
- Perform history and physical exam
- Look for other injuries (trauma)
- Keep patient NPO
- Follow your own hospital radiological response policy, if applicable.
- Consult the SBCC for assistance with care of the acutely and critically ill patient, to individualize the care of patient, if patient does not improve and needs to be transferred and as needed for further support and consult.
- Contact the IEMA Communication Center (1-217-782-7860 OR 1-800-782-7860) to report that any type of radiologic event has occurred and/or report that patients arriving at the hospital have been involved in any type of radiologic incident.
- It is recommended that hospitals consult REAC/TS (Radiation Emergency Assistance Center/Training Site) for questions regarding additional care management information (24 hour emergency phone number: 865-576-1005)

ATTACHMENT 18: ADULT BURN CARE GUIDELINES



ATTACHMENT 18: ADULT BURN CARE GUIDELINES



ATTACHMENT 18: ADULT BURN CARE GUIDELINES

Medical Management (Continued)

Medical management is dependent upon the type of specific isotope and the amount of exposure so identifying agent as quickly as possible is important.
Several categories of medical management for internal contamination:

1. Reduction and/or inhibition of absorption of isotope in the GI tract
2. Blocking uptake to the organ of interest
3. Isotope dilution
4. Altering the chemistry of the substance
5. Displacing the isotope from receptors
6. Traditional chelation techniques
7. Early excision of radionuclides from wounds to minimize absorption
8. Bronchoalveolar lavage for severe cases of insoluble inhaled particles

Extensive information for medical management of patients with radiation exposure can be obtain by contacting REAC/TS or in *The Medical Aspects of Radiation Incidents*, which can be found on REAC/TS website at www.orise.orau.gov/reacts

The following medications (potassium iodide and Prussian blue) can be obtain through the Strategic National Stockpile (SNS). Hospitals should follow their existing policy to request medications from the SNS. For questions or concerns regarding the policy to request medication from the SNS, hospitals can contact their local health departments, Regional Hospital Coordinating Center (RHCC) or the SBCC.

Potassium Iodide (KI)

Dose varies between 16 mg and 130 mg PO daily depending on:

- Age
- Thyroid exposure level
- If patient is pregnant or lactating

Protective effects of KI lasts approximately 24 hours and is usually given once. If patient is unable to be evacuated to a safer area within 24 hours, contact the SBCC for the possible need for repeat doses.
Breastfeeding:

The Food and Drug Administration (FDA) and American Academy of Pediatrics (AAP) have each released recommendations for breastfeeding after a mother has been exposed to radiation. The FDA's recommendation is a mother can breast feed after she has been treated with KI. The AAP recommends that mothers do not breast feed, even if they have been treated with KI unless no other alternative is available. For more information or assistance with determining if breast feeding should continue, consult the Pediatric Care Medical Specialist and/or REAC/TS.

Prussian Blue

Prussian Blue is utilized when the source is cesium, rubidium or thallium. The dosing recommendations are:

- Adults and adolescents: 3 g PO TID

ATTACHMENT 18: ADULT BURN CARE GUIDELINES

MANAGEMENT OF BURNS AFTER RADIATION INCIDENT

Partial thickness burns:

- Always irrigate thoroughly and clean with mild solutions
- Leave blisters closed
- Irrigate open blisters
- Once cleaned, treat the same as other partial thickness burns

Full thickness burns:

- Radioactive contaminate will slough in eschar
- Because there is no circulation in burned tissues, contaminates will remain in layers of dead tissue
- Excision of wounds is appropriate when surgically indicated
- Radioactive contaminants in wound surfaces will be removed with the tissue

Approximate Thresholds for Acute Radiation Syndromes

Dose		Signs/Symptoms*
0-100 rads (0-1 Gy)	NA	Generally asymptomatic, potential slight drop in lymphocytes later (near 1 Gy)
> 100 rads (> 1 Gy)	Hematopoietic	Anorexia, nausea, vomiting, initial granulocytosis and lymphocytopenia.
> 6-800 rads (> 6-8 Gy)	Gastrointestinal	Early severe nausea, vomiting, watery diarrhea, pancytopenia
> 2000 rads (> 20 Gy)	Cardiovascular/ CNS	Nausea/vomiting within first hour, prostration, ataxia, confusion

* At higher doses the time to onset of signs/symptoms may be compressed.

Psychological Considerations

Radiation emergencies, whether it be from a leak at a nuclear power plant or from a terrorist type incident such as a dirty bomb, leads to significant public anxiety. The anxiety associated with such events can appear out of proportion to the radiation induced health effects and can greatly affect the entire community. Many patients may present with symptoms such as nausea. It is important for providers to determine if nausea is from contamination or from the anxiety of the event. Long term psychological effects can manifest years after an event. General examples of long term effects include: feelings of vulnerability, PTSD, chronic anxiety, feelings of loss of control, fear of safety and health of themselves as well as future generations, and multiple idiopathic physical symptoms (MIPS). Provide educational materials and counseling options to all patients and their families after a radiological emergency.

Radioactive Contamination versus Exposure

- Radioactive contamination: radioactive material is on or inside a person
  - External contamination-radioactive material is only on outside of a person
  - Internal contamination-radioactive material is ingested, inhaled, or absorbed through the skin or open wound
- Radiation exposure: a person is exposed to radioactive materials
- Difference between contamination and exposure:
  - Person exposed to radiation may not be contaminated. An radiation exposure means radioactive material penetrated the person's body. For a person to be contaminated with radioactive materials, the materials must be on or inside of the person's body.

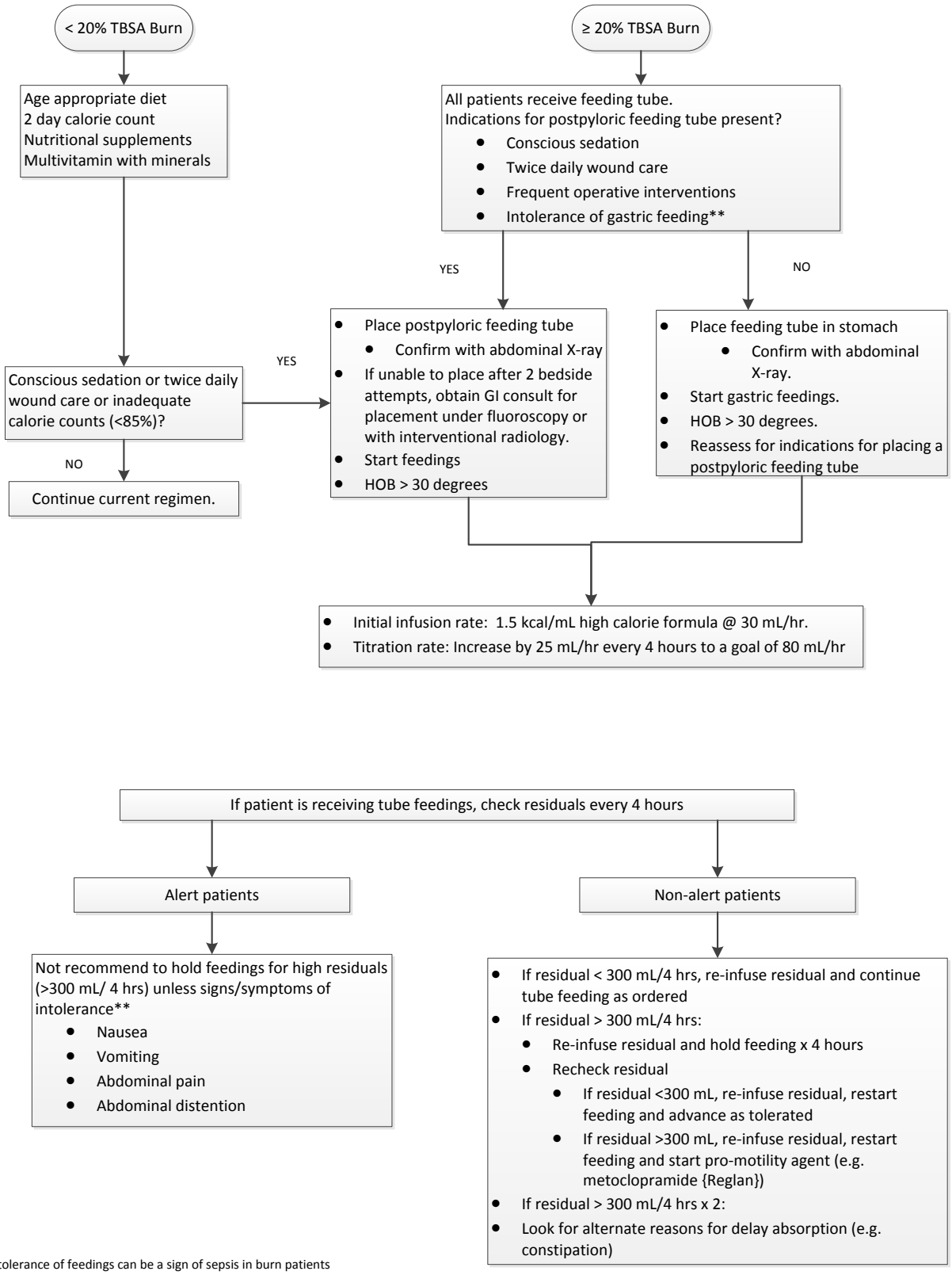
ATTACHMENT 18: ADULT BURN CARE GUIDELINES

General Information about Radiological Decontamination

- Typically is not emergently needed as compared to chemical decon
  - ***Can begin treatment for life threatening conditions before initiating decon***
  - Low risk to health care providers if decon is delayed
- Radioactive material cannot be neutralized, only moved from one point to another
- Clean dry sheet or drapes should be applied to the area to prevent spread of contamination to uncontaminated areas
- Standard considerations for decontamination apply:
- Clean wound via baby wipes or via irrigation
  - Options: baby wipes, irrigation, OR soft cloth with soap and tepid water
- Irrigation:
  - Irrigate would/orifice/area with sterile saline or equivalent
  - Prevent splashing
- Run-off should be directed into a receptacle (i.e. lined garbage can)
  - Keep all waste (run-off, absorbent pads, sheets, towels) for later collection and disposal
- Repeat until no further contamination is noted.
- Minor debridement may be needed if wound has foreign bodies in it
- After decon completed, clean wound as per hospital protocol.

ATTACHMENT 18: ADULT BURN CARE GUIDELINES

Nutritional Algorithm for Adult Burn Patients



** Intolerance of feedings can be a sign of sepsis in burn patients

ATTACHMENT 19: PEDIATRIC BURN CARE GUIDELINES

Purpose: Provide guidance to practitioners caring for pediatric burn patients during a disaster.
Instructions: These guidelines should be used as a reference by non-burn hospital providers when caring for pediatric burn patients for extended periods of time when the annex is activated during a burn MCI. These guidelines should be used in conjunction with medical consultation from the State Burn Coordinating Center (SBCC).
Disclaimer: This guideline are not meant to be all inclusive, replace an existing policy and procedure at a health care facility or substitute for clinical judgment. These guidelines may be modified at the discretion of the health care provider.

96 Hour Care Guidelines for Pediatric Burn Patients if Transfer to a Hospital with Burn Capabilities is Not Feasible

Initial Patient Treatment

- Stop the burning process
- Use universal precautions
- Remove all clothing and jewelry
- Prior to initiating care of the patient with wounds, it is critical that health care providers take measures to reduce their own risk of exposure to potentially infectious substances and/or chemical decontamination. Rinse liberally with water, according to protocol, if suspected chemical exposure. Apply clean, dry dressing(s) initially to avoid hypothermia.
- Apply clean DRY sheet or bedding to prevent hypothermia.
- For the care of a burn patient with radiation exposure, see page 106.
- Consult Pediatric Care Medical Specialist (PCMS) and/or the State Burn Coordinating Center (SBCC) for assistance with care of the acutely and critically ill patient, to individualize patient care; if patient does not improve and needs to be transferred; and as needed for further support and consult.
- Palliative care/comfort care patients: During a burn MCI, resources may not be available to treat those with extensive burn injuries. There are sections within the following guidelines that provide guidance to providers in order to address their needs. Consult the SBCC or the Pediatric Care Medical Specialist (PCMS) for additional assistance from palliative care experts.

Primary Assessment, Monitoring, Interventions and Key Points

Assessment and Monitoring	Interventions	Key Points
Airway Maintenance with Cervical Spine Motion Restriction • Assess throat and nares. • Signs of airway injury: o Hypoxia o Facial burns o Carbonaceous sputum o Stridor o Hoarseness o Nasal singe o History of a closed space fire	Airway Maintenance with Cervical Spine Motion Restriction • Chin lift/jaw thrust with C-spine motion restriction as needed. • IMMOBILIZE SPINE as indicated. Position for optimal airway and suction as needed. Position infants and children < 2 yrs supine on a backboard with a recess for the head or use a pad under the back from the shoulders to the buttocks.	Airway Maintenance with Cervical Spine Motion Restriction • Airway edema increases significantly after IV/IO fluids are started. • Stridor or noisy breath sounds indicate impending upper airway obstruction. • Younger children and those with larger burns are more likely to require intubation due to the smaller diameter of the child's airway and the need for significant fluid volumes during resuscitation. • Prophylactic intubation is preferred because the

ATTACHMENT 19: PEDIATRIC BURN CARE GUIDELINES

Assessment and Monitoring	Interventions	Key Points
	• Place an oral pharyngeal airway or cuffed endotracheal tube (ETT) in the unconscious patient • Intubate early with cuffed ETT. • Secure ETT with ties passed around the head; do not use tape on facial burns since it will not adhere to burned tissue. • Insert gastric tube on all intubated patients. • **Palliative care/comfort Care Patients**: Patients triaged as expectant or to receive palliative/comfort care only should not be intubated. Administer oxygen to aid comfort and prevent air hunger. Also consider pain management. See pages 101-102 for more guidelines.	ensuing edema obliterates landmarks needed for successful intubation. However, during a burn MCI, there is a need to consider resource availability (e.g. number of ventilators, number of trained staff to manage ventilators) ○ It is critical that the ETT is secured well. An ETT that becomes dislodged may be impossible to replace due to the edema of the upper airway.
<u>Breathing and Ventilation</u> • Assess for appropriate rate and depth of respirations with adequate air exchange. • Monitor pulse oximetry while checking carbon monoxide (CO) level (as needed). • If circumferential torso burns, monitor chest expansion closely. • Obtain Arterial Blood Gas (ABG). • Obtain Carboxyhemoglobin (COHb) level if suspected inhalation injury.	<u>Breathing and Ventilation</u> • 100%, high flow oxygen using a non-rebreather mask or ETT; wean as appropriate. • Mechanically ventilate as needed. Ventilator settings are not different for burn patients compared to other patients. • Elevate head of bed (HOB) if not contraindicated to decrease facial edema. • Consult with SBCC to determine if escharotomy is indicated and to receive guidance on performing an escharotomy.	<u>Breathing and Ventilation</u> • CO levels decrease by half (½) every 40 minutes while on 100% FiO_2. CO level goal is <10%. • An escharotomy is an incision performed longitudinally through burned tissue down to subcutaneous tissue over the entire involved area of full thickness circumferential (or nearly circumferential burn) that is causing constriction and loss of peripheral perfusion or airway constriction. A chest escharotomy may be indicated in circumferential or full thickness chest burns due to location or depth of burn in the trunk area, which may interfere with ventilation.
<u>Circulation with Hemorrhage Control</u> • Continuous cardiac monitoring as needed. • Control any signs of hemorrhage.	<u>Circulation with Hemorrhage Control</u> • Two large bore peripheral IVs in non-burned extremities (secure well). • If unable to secure peripheral IV in non-burned extremity, burned extremity can be	<u>Circulation with Hemorrhage Control</u> • Cardiac monitoring may be needed if there is an electrical injury, concurrent trauma or cardiac issues • Dysrhythmias may be the result of an electrical injury • To secure an IV on burned skin (tape will not stick),

ATTACHMENT 19: PEDIATRIC BURN CARE GUIDELINES

Assessment and Monitoring	Interventions	Key Points
	used if necessary; suture IV in place. • If unable to establish a peripheral IV, place an intraosseus (IO). IO access can be through burned skin. • Initial IVF with Lactated Ringers (LR) ○ ≤ 5 yrs. 125 mL LR/hour ○ 6-13 yrs. 250 mL LR/hour ○ ≥ 14 yrs. 500 mL LR/hour	consider suturing in place or using self-adhesive (e.g. Coban) or other type of wrap. Self-adhesive or other wraps should be applied loosely to prevent skin breakdown. • **Palliative care/Comfort care patients:** IVs should be started for the administration of medications for pain and anxiety. Do not administer large volumes of fluid. Excessive fluid will result in decreased circulation and increased pain due to edema.
<u>Disability</u> • Neurologic checks every 4 hours and PRN. ○ Determine level of consciousness. ○ Obtain Glasgow Coma Scale ○ Consider using "AVPU." ▪ A: Alert ▪ V: Responds to verbal stimuli ▪ P: Responds to painful stimuli ▪ U: Unresponsive • Obtain glucose level	<u>Disability</u> • Treat cause of altered mental status as indicated: ○ Hypoglycemia: ▪ Dose: Dextrose 0.5-1 g/kg IV/IO • Birth- 28 days: D10W: 2 mL/kg IV • Infants > 28 days- 1 y/o: D12.5%W: 5-10 mL/kg IV/IO • 1 y/o-8 y/o: D25W: 2-4 mL/kg IV/IO • > 8 y/o: D50W: 1-2 mL/kg IV/IO	<u>Disability</u> • If altered neurological status, consider the following: ○ Associated injuries ○ CO poisoning ○ Substance abuse ○ Hypoxia ○ Hypoglycemia (<60 mg/dL in infants/children; <50 mg/dL in neonates) ○ Pre-existing medical condition
<u>Exposure</u> • Monitor temperature	<u>Exposure</u> • Remove all clothing and jewelry. • Initially place a clean, dry sheet over the wounds until a thorough cleaning is done. • Keep patient and environment warm. ○ Keep patient covered ○ Cover the patient's head ○ Warm the room ○ Warm the IV/IO fluids	<u>Exposure</u> • Localized hypothermia causes vasoconstriction to damaged area reducing blood flow and tissue oxygenation and may deepen the injury. Systemic hypothermia (core temp less than 95° F / 35° C) induces peripheral vasoconstriction that may increase the depth of the burn and interfere with clotting mechanisms and respiration in addition, to causing cardiac arrhythmias. • Use portable radiant heaters with caution

ATTACHMENT 19: PEDIATRIC BURN CARE GUIDELINES

Assessment and Monitoring	Interventions	Key Points
	○ External patient warming devices	

Secondary Assessment, Monitoring, Interventions and Key Points

Assessment and Monitoring	Interventions and Key Points
History • Obtain circumstances of injury • Obtain medical history. Consider using "AMPLET." ○ Allergies, Medications, Previous illness/history, Last meal/fluid intake, Events related to injury, Tetanus and childhood vaccinations	History • Obtain history from patient early before intubation if possible. Obtain contact information for family as well.
Complete Physical Exam • Head to toe exam • Vital signs: Perform as indicated in health care facility policy. May need to perform more frequently if patient is unstable. ○ Heart rate (HR) ○ Blood pressure (BP) ○ Respiratory rate (RR) ○ Temperature ○ Pulse oximetry ○ Capillary refill ○ Skin color of unburned skin ○ Imperative to obtain weight on patient ▪ If possible obtain weight before initiating IVF resuscitation • Determine extent/size of burn by calculating the TBSA using: ○ Rule of Nines or Rule of the Palm (See page 105 for printable version) ○ Lund-Browder chart (See page 104 for printable version) • Determine the depth of the burn (See page 103 for more information) ○ *Superficial (1st degree)* ▪ Involves the epidermis,	Complete Physical Exam • Due to increased catecholamines and hypermetabolism associated with burn injures, the HR will be increased. Relative tachycardia is normal for burn patients (will vary based on the age of the patient). Sustained tachycardia may indicate hypovolemia, inadequate oxygenation, unrelieved pain or anxiety. • May need to use doppler to obtain blood pressure • Oral rehydration can be used in the following pediatric patients: ○ Patients not intubated. ○ Injury not an electrical injury. ○ Awake and alert with < 10% TBSA. ○ Contact the SBCC for assistance with oral rehydration. ○ Monitor quality and quantity of urine output on patient's receiving oral rehydration. • IV/IO fluid burn resuscitation-Use Lactated Ringers: ○ When supplies of LR are depleted, 0.9 NS and 0.45 NS or colloids can be used for fluid resuscitation. Do not use fluid containing glucose for fluid resuscitation. ○ 3 mL x wt (kg) x % TBSA = total for first 24 hours post burn. ○ Administer half of the above amount in first 8 hours post burn. ○ Administer remaining amount over next 16 hours post burn. • Pediatrics < 10 kg: Due to limited glycogen stores, in addition to resuscitation

ATTACHMENT 19: PEDIATRIC BURN CARE GUIDELINES

Assessment and Monitoring	Interventions and Key Points
▪ Appearance: Red (e.g., sunburn) ▪ Do not include when calculating % TBSA, ○ *Partial thickness (2nd degree)* ▪ Involves the entire epidermis and a variable portion of the dermis ▪ Appearance: red, blistered and edematous. ○ *Full thickness (3rd degree)* ▪ Involves the destruction of the entire epidermis and dermis ▪ Appearance: white, brown, dry, leathery with possible coagulated vessels • If camera is available, take pictures of initial burn injuries to document progression of burn injury. • Labs on admission and every day as indicated by medical condition: ○ Electrolyte panel ○ Complete blood count (CBC) ○ ECG for electrical injury or cardiac history ○ ABG with COHb ○ Cardiac panel for electrical injury • CXR if intubated, inhalation injury suspected or underlying pulmonary condition. • Monitor glucose at least every 2 hours x 24 hours. • Monitor for the following signs and symptoms in full thickness, circumferential burn injuries which may indicate a circulation deficit and possible need for escharotomy: (6 P's) ○ Pallor or cyanosis of distal unburned skin on a limb ○ Pain ○ Pulselessness ○ Paralysis ○ Paresthesia ○ Poikilothermia ○ Inability to ventilate in patients with deep circumferential	IV/IO fluids, administer D5% LR at maintenance rate: ○ To calculate maintenance IVF rate for children: ▪ 4 mL/kg/hr for 1st 10 kg + 2 mL/kg/hr for 2nd 10kg + 1 mL/kg/hr for each additional kg over 20kg = IV/IO fluid maintenance rate • The above calculation is a starting point for fluid resuscitation. IVF rate should be titrated to maintain urine output. ○ Pediatrics <30 kg: 1 mL/kg ○ Pediatrics >30 kg: 0.5 mL/kg • Tetanus prophylaxis, unless received within last 5 years. • Place a soft feeding tube for all intubated patients. Feedings should be initiated within 6 hours of injury. • The goal in the early stages of burn resuscitation should be to maintain the individual's pre-event BP. • If signs of circulation deficit are present, contact the SBCC. • Eyes: ○ Remove contact lens prior to eyelid swelling if facial involvement. ○ Fluorescein should be used to identify corneal injury. ○ If eye involvement or facial burns consider, consulting an ophthalmologist. • Consult with SBCC to determine if escharotomy is indicated and to receive guidance on performing an escharotomy. • Finger escharotomies are rarely indicated.

ATTACHMENT 19: PEDIATRIC BURN CARE GUIDELINES

Assessment and Monitoring	Interventions and Key Points
burns of the chest	

<u>Comfort</u>
• Frequent pain/sedation assessment
  ○ A minimum of every 4 hours
  ○ Before and after pain/sedation medication given
• Use age appropriate pain scales for pediatric patients (e.g., Wong Baker FACES, FLACC)
	<u>Comfort</u>
	• Emotional support and education is essential.
	• IV/IO analgesia is preferred route during initial post injury period.
	• Large amounts of IV/IO analgesic may be required to attain initial pain control.
	  ○ Administer opioids in frequent (every 5 minutes) small to moderate doses until pain is controlled.
	  ▪ Morphine 0.1-0.2 mg/kg IV/IO (max 10mg/dose)
	  ▪ Fentanyl 1-2 mcg/kg/dose IV/IO/IN (not to exceed maximum adult dose)
	  ○ Hydrocodone/acetaminophen 0.1-.02 mg/kg PO/NO/OG every 4-6 hours
	  ○ Acetaminophen-codeine (Tylenol #3) 0.5-1mg/kg/dose PO/NG/OG every 4-6 hours (NOTE: Not recommended in children < 2 y/o)
	• Consider use of non-pharmacological techniques.
	  ○ Examples:
	  ▪ < 2 y/o: distraction
	  ▪ 2-6 y/o: distraction, deep breathing
	  ▪ > 6 y/o: deep breathing, distraction, imagery
	• Consider anti-anxiety medication in addition to pain medication.
	  ○ Lorazepam (Ativan) PO/IV/IO
	  ○ Midazolam (Versed) IV/IO/IN
	• Consider sedation for procedures and, if intubated:
	  ○ Ketamine
	  ○ Lorazepam (Ativan®)
	  ○ Midazolam (Versed®)
	  ○ Dexmedetomidine (Precedex®)

<u>Wound Care</u> • Maintain temperature of patient since they are prone to hypothermia • Assess the wound and monitor for:	<u>Wound Care</u> • Pre-medicate patients for pain and anxiety before wound care. • In a mass casualty disaster situation wound care for patient with a >20% TBSA burn can be performed once per day.

ATTACHMENT 19: PEDIATRIC BURN CARE GUIDELINES

Assessment and Monitoring	Interventions and Key Points
○ Change in wound appearance ○ Change in size of wound ○ Signs or symptoms of infection • Describe what you see: ○ Color (e.g. white, leathery, or pink, moist) ○ Sensation (distinguish between pain and sensation) ○ Temperature ○ Swelling ○ Cellulitis (redness around the wound) ○ Odor (foul smelling, sweet smelling, etc.) ○ Drainage (amount, type) • Compartment syndrome ○ Can have in non-burned limbs and abdomen • Check of the circulation of an extremity before and after wound care	• Contraindications for silver sulfadiazine (Silvadene): ○ Patient's with a sulfa allergy ○ During pregnancy Instead use another topical or wound coverage product. • Wash wounds with soap and warm tap water using a wash cloth. ○ Remove water by patting dry • Shave daily for burned scalps and faces. • Perform wound care every day if using: ○ Silver sulfadiazine (Silvadene) cream ○ Bacitracin • Debride ALL blisters except for: ○ Intact blisters on hands and feet unless it is impeding range of motion to the joints, ○ Weeping blister(s). • Ear wound care: ○ Ears are poorly vascularized and at risk for chondritis. • How to apply silver sulfadiazine (Silvadene) cream: ○ Apply thin layer enough so that the wound cannot be seen through the cream. ○ The layer of silver sulfadiazine (Silvadene) should be thick enough to prevent the wound from drying out prior to the next dressing change. ○ Cover with a dressing; the purpose of a dressing is to keep the cream from rubbing off before the next dressing change. • How to apply silver impregnated antimicrobial dressings (e.g., Acticoat®, Mepilex): ○ Apply a single layer of the dressing moistened with water over burn wounds so that all areas are covered. ○ Water should be used to keep the dressing and overlying gauze moist to maintain the dressing's antimicrobial activity. (*DO NOT use saline because it deactivates the silver's antimicrobial ability)*. ○ Should be held in place with water-moistened gauze dressing. ○ Dressing does not need to be changed for 7 days.

ATTACHMENT 19: PEDIATRIC BURN CARE GUIDELINES

Assessment and Monitoring	Interventions and Key Points
	○ The overlying gauze can be changed as necessary. ○ If signs of infection appear, remove dressing to assess wound. ○ Record the date of the application. • Wrap fingers separately if burned. • Place silver sulfadiazine (Silvadene) coated gauze between the toes. • For extensive and severe burns to the face: ○ Apply a double antibiotic ointment around the eyes and mouth to avoid cream from draining into them. ○ Can use ophthalmic ointment around eyes. ○ Silver sulfadiazine (Silvadene) can be used on the face • For moderate facial burns, Bacitracin or other antibiotic ointment can be used without a dressing. • Genital/Perineal Burns ○ Urinary catheter may be indicated for genitalia or perineal burns. Evaluate each patient individually to determine if needed. ○ Apply lubricated gauze to labia and in the foreskin to prevent adhesions and decrease risk of infection in this area of high contamination. • Elevate burned extremities above the level of the heart.

Ongoing Assessment, Monitoring, Interventions and Key Points

Assessment and Monitoring	Interventions
Airway and Breathing • Obtain chest X-ray if intubated, inhalation injury suspected or underlying pulmonary condition. • Chest X-ray will usually be clear on admit. If inhalation injury is present, the X-ray will show infiltrates around the second day correlating with a deteriorating oxygen status. • Frequent suctioning is necessary to prevent occlusion of the airway and endotracheal tube. Anyone with an inhalation injury is subject to increased respiratory secretions and may have a large amount of carbonaceous debris in the	Airway and Breathing • Supportive therapy and O_2; wean as appropriate. • HOB should be elevated 30 degrees to minimize facial and airway edema, unless contraindicated. ○ Use reverse Trendelenburg for patients with C-spine motion restriction requirements. • Suction airway frequently. • **Inhalation Injuries:** ○ Treatment for inhalation injury is supportive care and includes: ▪ Intubation as indicated

ATTACHMENT 19: PEDIATRIC BURN CARE GUIDELINES

Assessment and Monitoring	Interventions
respiratory tract. • Airway edema peaks at 36 hours post burn • Weaning from the ventilator and extubation: ○ CO level should be normalized (< 10%) for at least 6 hours ○ There is an Increased risk of needing to re-intubate inhalation injury patients so maintain intubation equipment at bedside after extubation ○ Don't extubate patient unless there is a leak around the ETT cuff	▪ Provide adequate sedation to prevent dislodgement of ETT ▪ Frequent suctioning ▪ Positive End Expiratory Pressure (PEEP) may improve ventilation ○ Secure ETT with ties instead of tape since tape will not adhere to burned tissue ○ Mark ETT at fixed position (teeth or gums not lips which may have swelling)
<u>Circulation/Outputs of Resuscitation</u> • Monitor mean arterial blood pressure (MAP): ○ Goal for MAP is > 60 mmHg • Monitor hourly urine output: ○ Goal: 1 mL/kg/hr for children < 30 kg • Monitor for myoglobin/pigment in urine (burgundy color). • Additional resuscitation fluid needs can occur with: ○ Very deep burns ○ Inhalation injury ○ Associated injuries ○ Electrical injury ○ Delayed resuscitation ○ Prior dehydration ○ Alcohol or drug dependence ○ Small children • Children and patients with preexisting cardiac disease are particularly sensitive to fluid management. • Diuretics are not indicated in myoglobin in the urine. • Monitor glucose at least every 2 hrs x 24 hours. • May take > 24 hours to see signs of adequate resuscitation: ○ Normalization of blood pH	<u>Outputs of Resuscitation</u> • Insert arterial line. • Insert urinary catheter. • If urine output is < goal, ↑ fluids by 1/3. ○ Example: u/o for 20 kg pediatric patient = 10 mL/hr, fluid rate at 50 mL/hr, ↑ to 66 mL/hr • If urine output is > goal, ↓rate of infusion by 1/3. ○ Example: u/o for 20 kg pediatric patient = 30 mL/hr fluid rate at 50 mL/hr, ↓to 33 mL/hr • Upon completion of the resuscitation phase (typically 24 hrs post burn), ↓ hourly fluid volume by 10% per hour to a maintenance fluid with D5 0.45 NS with 20 mEq KCL/L. ○ Check serum sodium and potassium on day 2 post burn • Myoglobin in urine: ○ Maintain urine output: ▪ 2 mL/kg/hr ○ Increase fluid rate (LR). • Oliguria or anuria requires mostly due to inadequate fluid resuscitation and requires more rapid fluid administration. **Diuretics are contraindicated**! • Treatments for hypotension: ○ Albumin human 5% injection (consult SBCC before using)

ATTACHMENT 19: PEDIATRIC BURN CARE GUIDELINES

Assessment and Monitoring	Interventions
○ Improved peripheral circulation ○ Clearing sensorium (more alert) ○ Stable BP • If IVF requirements are still high after 24 hours of crystalloids, contact the SBCC for medical consultation.	○ Vasopressors initiated when MAP is low despite adequate fluid resuscitation ▪ Use institution specific dosing ranges
<u>Circulation</u> • Perform pulse checks (CMS) every 1 hour if there are circumferential burns on extremities. ○ Monitor pulses by palpation or doppler exam. ▪ Decreased sensation ▪ Severe unrelenting deep tissue pain ▪ Diminished distal pulses ▪ Capillary refill > 5 sec • After 24-48 hrs decrease frequency of pulse checks to every 2 hours if stable. • Assess bowel sounds to monitor for ileus.	<u>Circulation</u> • Elevate burned extremities on pillows or blankets to improve circulation and minimize edema. • Circumferential chest injuries may become life threatening; an escharotomy may be necessary. • Verify that pulselessness is not due to profound hypotension. • Scrotal swelling, though often significant, does not require specific treatment.
<u>Body Temperature</u> Perform temperature checks based on health care facility protocol. • If unstable or significant burn, hourly vital signs may be indicated.	<u>Body Temperature</u> • With 2nd and 3rd degree burns, patients may have difficulty regulating their temperature; monitor for hypo and hyperthermia. • Keep patient normo-thermic, especially during wound care. • Keep patient covered. When supplies of blankets are depleted, patients can be wrapped in plastic wrap or aluminum foil for insulation and warmth. • Warm the room. • Warm IV/IO fluid if possible, especially if patient is very hypothermic.
<u>Other Pharmaceutical Considerations</u>	
• Stress ulcer prophylaxis ○ Begin feedings within 6 hours of injury ○ Start on prophylaxis medications if intubated (based on institutional preference, hospital formulary and availability • Anti-emetics ○ Use cautiously (enteral feeding intolerance can be a sign of sepsis in burn patients) ○ Ondansetron (Zofran®) • Itching	

ATTACHMENT 19: PEDIATRIC BURN CARE GUIDELINES

<table>
<tr><th>Assessment and Monitoring</th><th>Interventions</th></tr>
<tr><td colspan="2">

Diphenhydramine (Benadryl®)
Hydroxyxine (Atarax®)

Vitamin Supplements

Start vitamins after feedings (via tube or PO) are initiated
Multivitamins
Ascorbic acid
Zinc sulfate
Glutamine (if available and on formulary)

Venous thromboembolism prophylaxis

<u>Consult SBCC/pediatric experts before starting</u>

</td></tr>
<tr><td>
<u>Nutrition</u>

Obtain dry weight on admission.
Nutritional plan should start < 6 hours post injury
Increased need for protein, calories, vitamins and minerals for wound healing
Adequate intake is more important than route of intake
TPN is rarely used. Oral feedings (via tube or PO) provides most benefit for burn patients.
Indications for feeding tube:

Intubated
>20% TBSA
Unable to maintain caloric needs via PO

Indications for post pyloric feeding tube:

Conscious sedation
Twice daily wound care
Frequent operative interventions
Intolerance of gastric feeding (nausea, vomiting, increased gastric residuals)

See Nutritional Algorithm for Pediatric Burn Patients on page 111 for initial infusion rates, titrating feeding rates and residual check

</td><td>
<u>Nutrition</u>

Consult hospital dietitian to adjust nutritional plan based on lab result trends (CRP, Prealbumin, albumin & transferrin)
Conduct daily calorie counts
Daily calorie needs based on % TBSA, weight and age

Consult SBCC and pediatric experts for calculations

Increased protein needs.

20 % of calories should be from protein (approximately 2.5 - 4.0 grams protein/kg)

Regular high calorie, high protein diet if able to take PO.

If unable to maintain adequate caloric requirements, initiate tube feedings.

No free water drinks (plain water) if taking PO, only high calorie liquids.
Ensure stool softeners are ordered to prevent constipation due to pain medications.
Begin enteral nutrition as soon as possible.
Soft feeding tubes are preferred over hard salem sump nasogastric tube.
Titrating patient off tube feedings to PO

Switch to night feedings first
If eating during the day and taking in enough calories, can progress to PO feedings only
Titrating might be done in acute rehab setting and not in hospital setting

</td></tr>
<tr><td colspan="2"><u>Infection Control</u></td></tr>
</table>

ATTACHMENT 19: PEDIATRIC BURN CARE GUIDELINES

<table>
<tr><th>Assessment and Monitoring</th><th>Interventions</th></tr>
<tr><td colspan="2">

Utilize universal precautions.
If wounds are exposed:
Apply gown, mask and gloves to protect patient.
No systemic antibiotics are required for the burn injuries.

</td></tr>
<tr><td>
<u>Splinting, Positioning and Mobility</u>

In a disaster, physical and occupational therapists may splint patients in functional positions and help with dressings.
Rehabilitation (splinting, positioning and mobility) should be initiated early on in care of patient
Check circulation status of extremities before and after positioning and splinting
Monitor for pressure areas under splints

</td><td>
<u>Splinting, Positioning and Mobility</u>

Obtain physical therapy /occupational therapy consult.
Early mobilization of patients
HOB elevated at all times.
Elevate burned extremities above the level of the heart.
Positioning:

Degree of functioning preserved depends on early intervention and prevention of further tissue damage
Designed to:

Minimize edema formation
Prevent tissue destruction
Maintain soft tissue in an elongated state to facilitate optimal functional recovery

Use whatever tools are available to assist (e.g., pillows, towels, splints, bedside tables, wedges).
Neck burns

Maintain the head in a neutral position.
No pillows or blankets under the head flexing the neck forward.

Axilla burns

Keep arms extended to decrease contractures.

Ear burns

No external pressure should be applied.
No pillows or blankets under the head.

Out of bed (OOB) - If legs are burned, apply ace wraps when OOB.
Encourage active range of motion hourly when awake.
Encourage activities of daily living.
Splinting:

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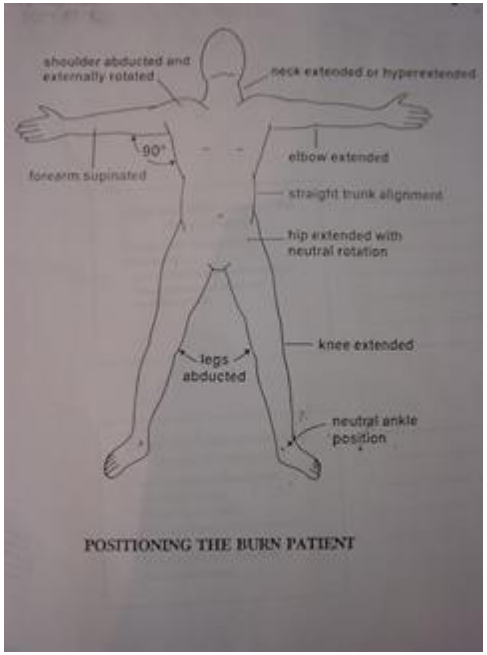
ATTACHMENT 19: PEDIATRIC BURN CARE GUIDELINES

Assessment and Monitoring	Interventions
	○ Use either ace/elastic wraps, gauze rolls/wraps, strappings with post-mold material (e.g., thermoplastic-perforated), or whatever is available ○ Wearing schedule: ▪ 24 hours/day except for dressing changes and range of motion exercises ▪ At night only for compliant patients who are able to perform exercises independently ▪ Post wearing schedule at patient's bedside

Proper Positioning of a Burn Patient

Area Involved	Contracture Predisposition	Contracture Preventing Position
Anterior neck	Flexion	Extension, no pillows
Anterior axilla	Shoulder adduction	90° abduction, neutral rotation
Posterior axilla	Shoulder extension	Shoulder flexion
Elbow/Forearm	Flexion/pronation	Elbows extended, forearm supinated
Wrists	Flexion	15°–20° extension
Hands:		
MCPs	Hyperextension	70°–90° flexion
IPs	Flexion	full-extension
Palmar Burn	Finger flexion, thumb opposition	All joints full extension, thumb radially abducted
Chest	Lateral/anterior flexion	Straight, no lateral or anterior flexion
Hips	Flexion, adduction, external rotation	Extension, 10° abduction, neutral rotation
Knees	Flexion	Extension
Ankles	Plantar flexion	90° dorsiflexion



Reunification

During a large scale disaster, family members may become separated. It is crucial that staff attempt to reunify patients with their family. Children are more vulnerable to maltreatment, abuse and abduction, if separated from their care giver. Community partners, such as the American Red Cross and National

ATTACHMENT 19: PEDIATRIC BURN CARE GUIDELINES

Assessment and Monitoring	Interventions
Center for Missing and Exploited Children, can assist with this process. The reunification process begins with EMS at the scene and, if possible, trying to keep known family members together when making transport decision. The Patient Identification Tracking Form (Attachment 12 in Burn Surge Annex) should be utilized for all patients to assist with the reunification process.	

<u>Psychosocial</u>
• Address the psycho-social needs of burn patients
  ○ Immediate needs (pain, fear of unknown, similar to any trauma patient)
  ○ Long term needs (more ongoing, can need support for years)
• Treatment therapies may trigger traumatic response
• Explain any procedures.
• Involve patient and family.
• Consider social worker consultation.
• Offer spiritual care.
• Consult child life specialists, if available.
• Child's needs and understanding of the injury and care will vary based on their developmental level.
  ○ Infants
  ▪ Learn through sensory stimulation (especially touch) and movement.
  ▪ Can experience separation anxiety from family/care taker.
  ○ Toddler/Preschool
  ▪ May see the burn injury as punishment for being "bad" so at risk for ineffective coping.
  ▪ Routine is important so coordinate procedures around daily routines.
  ○ School age
  ▪ Anxiety can be decreased by providing child education about processes and involving child in care.
  ○ Adolescent
  ▪ Body image is significant concern.	

<u>Palliative Care/Comfort Care</u> During disasters, patients with extensive burn injuries may be triaged as Expectant based on the Burn Triage Guidelines. Patient's triaged as Expectant still need palliative care/comfort care provided. See the following page for additional information	

ATTACHMENT 19: PEDIATRIC BURN CARE GUIDELINES

PALLIATIVE CARE COMPONENTS DURING DISASTER MANAGEMENT	
PATHWAY COMPONENT	**CONSIDERATIONS**
Assess the situation	Health of the patient Family dynamic if present
Identify key players	Patient needs Family and friends needs Physician needs Nurses needs
Consider the big picture of the key players	Staff Concerns and any distress of key players Psychological Symptoms of any key players Distress Physical Symptoms of the patient Pain Dyspnea Existential and Spiritual Symptoms of any key players Examples: o Last rites from a priest with Catholic backgrounds o Imam being available for Islamic backgrounds o Hindu and Buddhists have their own beliefs and requests at the end of life. Some request the patient being put on the floor, we never do this put we do lower the bed all the way to the floor. Legal and Ethical Aspects of Care Any member of the key players uncomfortable with end of life pathways Cultural Aspects of Care Examples: o Family requests for positioning of patient o Turing the bed toward specific directions if requested o Having LED candles available if family requests candles around the body End of Life Logistics Find a location that is accessible for family and friends
Communication	Set expectations and maintain communication
Develop and implement plan	Develop Plan/Manage Death: Implement postmortem logistics Pronouncing death Bereavement Staff debriefing/support
Manage pain, dyspnea, and agitation at the end of life	Family and nursing input is essential Don't forget that using opioids with the intent to control symptoms at the end of life is ethically appropriate Assess: • Distress • Pain: grimace, tachycardia, verbal cues • Agitation: writhing, sweating • Dyspnea: retractions, flaring, tachypnea Un-intubated patients: • Pain or dyspnea: Intermittent IV dosing preferred: Morphine and hydromorphone preferred o Reassess every 10 minute; repeat dose if needed Agitation: Benzodiazepines preferred: Lorazepam and haloperidol preferred Intubated patients: • Pain: Continuous IV infusions preferred: Morphine, fentanyl, and hydromorphone preferred • Agitation: Continuous IV infusions preferred: Midazolam and lorazepam preferred • Increase the dosing every ten minutes • If distress is present, bolus the mediation by one hour equivalent and increase infusion by 25 to 100%. Write orders allowing for titration

ATTACHMENT 19: PEDIATRIC BURN CARE GUIDELINES

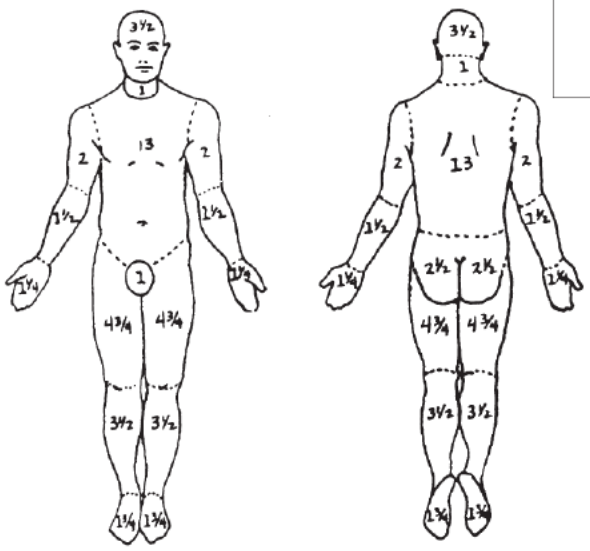
Assess Degree of Injury

	APPEARANCE	SURFACE	SENSATION	TIME TO HEALING
1st degree/superficial	Pink or red	Dry	Painful	4-5 days
2nd degree/superficial partial thickness	Pink, clear blisters	Moist, weeping	Painful	14–21 days
2nd degree/deep partial thickness	Pink, hemorrhagic blisters, red	Moist	Painful	Weeks, may progress to 3rd degree and require graft, may lead to contractures
3rd degree/full thickness	White, brown, charred	Dry, waxy, leathery	Painless	Requires excision, high risk for infection/fluid loss
4th degree (tendon, nerve, muscle, bone and/or deep fascia involvement)	Brown, charred	Dry	Painless	Requires excision, high risk for infection/fluid loss

ATTACHMENT 19: PEDIATRIC BURN CARE GUIDELINES

Lund & Browder Chart

BURN DIAGRAM, ESTIMATE
(Lund & Browder)



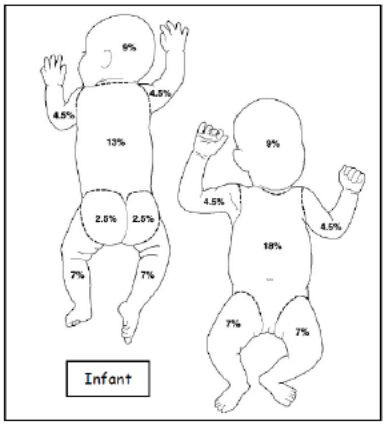
	AGE						BURN ASSESSMENT	
AREA	**infant**	**1-4**	**5-9**	**10-14**	**15**	**adult**	PARTIAL THICKNESS	FULL THICKNESS
head	19	17	13	11	9	7		
neck	2	2	2	2	2	2		
ant. trunk	13	13	13	13	13	13		
post. trunk	13	13	13	13	13	13		
r. buttock	2 1/2	2 1/2	2 1/2	2 1/2	2 1/2	2 1/2		
l. buttock	2 1/2	2 1/2	2 1/2	2 1/2	2 1/2	2 1/2		
genitalia	1	1	1	1	1	1		
r. u. arm	4	4	4	4	4	4		
l. u. arm	4	4	4	4	4	4		
r. l. arm	3	3	3	3	3	3		
l. l. arm	3	3	3	3	3	3		
r. hand	2 1/2	2 1/2	2 1/2	2 1/2	2 1/2	2 1/2		
l. hand	2 1/2	2 1/2	2 1/2	2 1/2	2 1/2	2 1/2		
r. thigh	5 1/2	6 1/2	8	8 1/2	9	9 1/2		
l. thigh	5 1/2	6 1/2	8	8 1/2	9	9 1/2		
r. leg	5	5	5 1/2	6	6 1/2	7		
l. leg	5	5	5 1/2	6	6 1/2	7		
r. foot	3 1/2	3 1/2	3 1/2	3 1/2	3 1/2	3 1/2		
l. foot	3 1/2	3 1/2	3 1/2	3 1/2	3 1/2	3 1/2		
						TOTAL:		

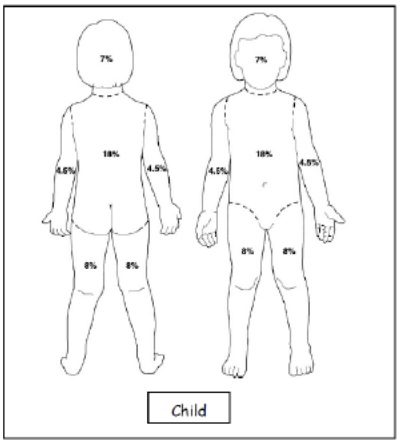
BURN ASSESSMENT: Date _____ Time _____ Signature _____

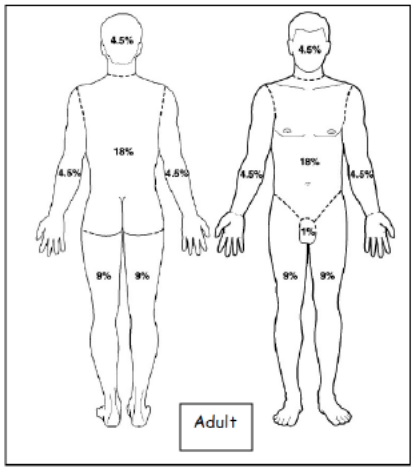
ATTACHMENT 19: PEDIATRIC BURN CARE GUIDELINES

Rule of 9's Charts:

BURN DIAGRAM ESTIMATE
(Rule of 9's: Estimate of TBSA – Total Burn Surface Area)







Area	Infant	Child	Adult	Burn Assessment	
				Partial thickness	Full thickness
Head	18	14	9		
Chest (Ant. torso)	18	18	18		
Back (Post. Torso) & buttocks	13 (back) 5 (buttocks)	18	18		
Rt. arm & hand	9	9	9		
Lt. arm & hand	9	9	9		
Rt. Leg & foot (anterior)	7	8	9		
Lt. Leg & foot (anterior)	7	8	9		
Rt. Leg & foot (anterior)	7	8	9		
Rt. Leg & foot (anterior)	7	8	9		
Perineum	(include with chest)	(include with chest)	1		

Bolded areas = nine or multiple of nine

Burn Assessment Date_____ Time _____ Signature_____

ATTACHMENT 19: PEDIATRIC BURN CARE GUIDELINES

MANAGEMENT OF BURN PATIENTS WITH RADIATION EXPOSURE

Initial Management of All Pediatric Patients Involved in Radiological Event

- Determine if decontamination is needed due to external contamination (See below and pages 107 and 110 for information specific to decon)
- Stabilize ABCs (Airway, Breathing, Circulation)
- Immobilize spine as indicated
- Perform history and physical exam
- Look for other injuries (trauma)
- Keep patient NPO (including pacifiers)
- Follow your own hospital radiological response policy, if applicable.
- Consult the SBCC and the Pediatric Care Medical Specialist for assistance with care of the acutely and critically ill patient, to individualize the care of patient, if patient does not improve and needs to be transferred and as needed for further support and consult.
- Contact the IEMA Communication Center (1-217-782-7860 OR 1-800-782-7860) to report that any type of radiologic event has occurred and/or report that patients arriving at the hospital have been involved in any type of radiologic incident.
- It is recommended that hospitals consult REAC/TS (Radiation Emergency Assistance Center/Training Site) for questions regarding additional care management information (24 hour emergency phone number: 865-576-1005)

Steps for Decontaminating Externally Contaminated Pediatric Patients

- Admit to controlled area
- Remove clothing (cut clothing in direction away from patient's airway and roll it outward away from patient's skin, trapping any material inside the clothes)
- Place all clothing in plastic bags for testing

↓

- ***Assess for and stabilize any emergent medical issues***
- Obtain medical/event history if patient or family able to provide
- Identify/contain contaminate
- Minimize any additional possible intake
- Follow IEMA, REAC/TS, and/or Department of Nuclear Safety recommendations
- See next page for general Information about Radiological Decontamination

↓

Decontamination Order Priority:
1. Wounds
2. Body Orifices
3. Intact skin

↓

Reassess all areas after decon

↓

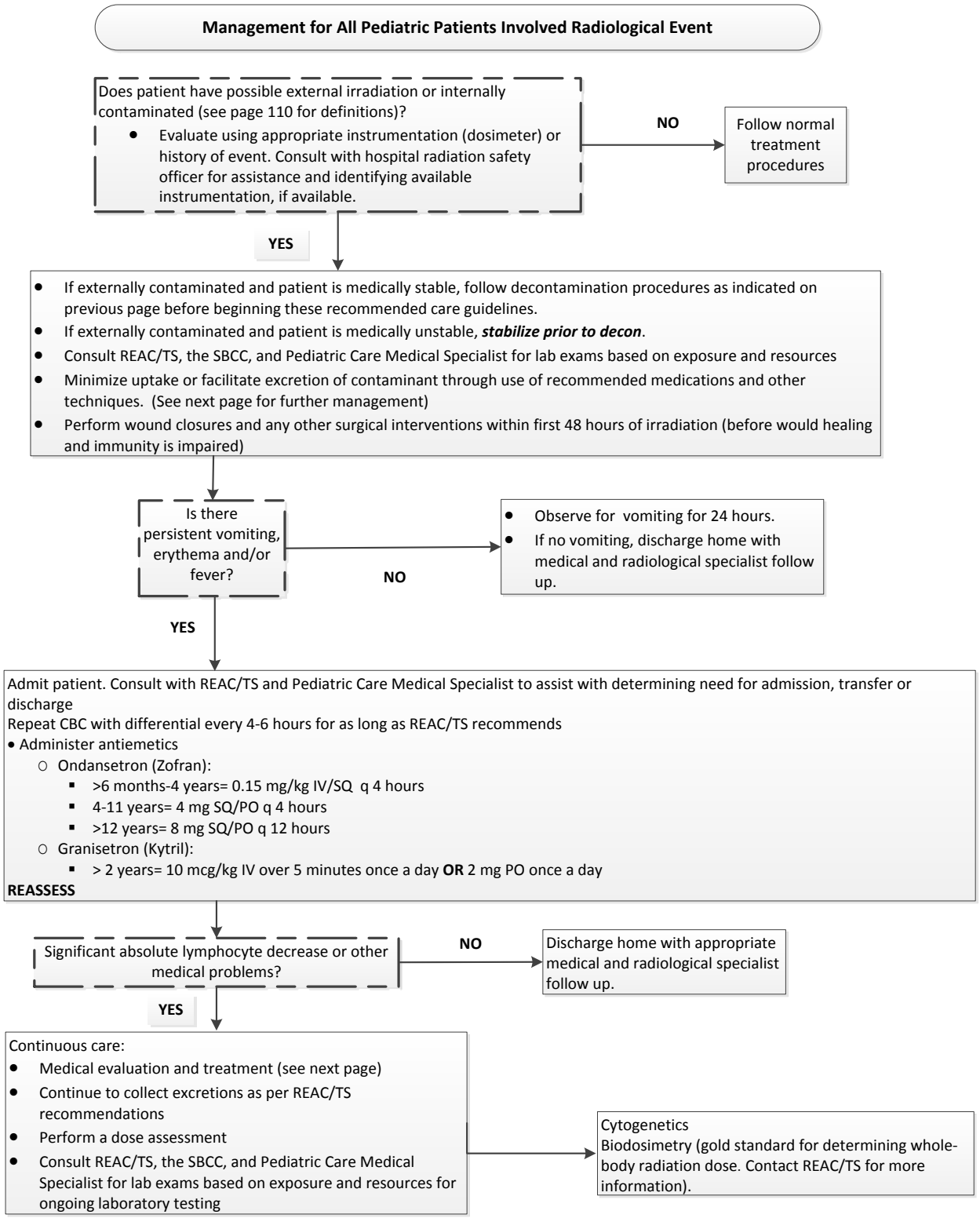
Contamination reduced to acceptable levels?

NO → Decontamination Order Priority

YES ↓

Begin medical treatment (see next page)

ATTACHMENT 19: PEDIATRIC BURN CARE GUIDELINES



ATTACHMENT 19: PEDIATRIC BURN CARE GUIDELINES

Medical Management (Continued)

Medical management is dependent upon the type of specific isotope and the amount of exposure so identifying agent as quickly as possible is important.
Several categories of medical management for internal contamination:

1. Reduction and/or inhibition of absorption of isotope in the GI tract
2. Blocking uptake to the organ of interest
3. Isotope dilution
4. Altering the chemistry of the substance
5. Displacing the isotope from receptors
6. Traditional chelation techniques
7. Early excision of radionuclides from wounds to minimize absorption
8. Bronchoalveolar lavage for severe cases of insoluble inhaled particles

Extensive information for medical management of patients with radiation exposure can be obtain by contacting REAC/TS or in *The Medical Aspects of Radiation Incidents*, which can be found on REAC/TS website at www.orise.orau.gov/reacts

Safety and effectiveness of many of the therapy recommendations have not been established in the pediatric patient. Contact Pediatric Care Medical Specialist and/or REAC/TS representative for treatment recommendations.

The following medications (potassium iodide and Prussian blue) can be obtain through the Strategic National Stockpile (SNS). Hospitals should follow their existing policy to request medications from the SNS. For questions or concerns regarding the policy to request medication from the SNS, hospitals can contact their local health departments, Regional Hospital Coordinating Center (RHCC) or the Pediatric Care Medical Specialist.

Potassium Iodide (KI)

Children are susceptible to thyroid cancer after being exposed to radioactive iodine. The uptake of radioactive iodine needs to be blocked by administering oral potassium iodide (KI) **within 4 hours** of exposure for exposures of ≥ 0.05 Gy (5 rad). See the dosing chart below.

Age of Patient	Dose
<1 month	16mg PO
1 month-3 years	32 mg PO
4-18 years	65 mg PO
Pregnant or lactating women	130 mg PO

Protective effects of KI lasts approximately 24 hours and is usually given once. If child is unable to be evacuated to a safer area within 24 hours, contact Pediatric Care Medical Specialist for the possible need for repeat doses.
If liquid form is not available, below are the steps for how to convert the KI tabs to KI solution:

1. Place one 130mg tablet (or two 65mg tablets) into a bowl and grind into a fine powder.
2. Add 20ml of water to bowl and dissolve the KI powder.
3. Add 20ml of milk, juice, soda or syrup to flavor the KI/water mixture
4. Resulting solution has a concentration of 16.26mg/5ml
5. Unused iodine mixture may be stored in the refrigerator for up to 7 days.

Other considerations:

- Need to monitor a newborn's thyroid function 2-3 weeks after receiving KI because KI can cause a transient decrease in thyroxin and increase in the TSH level
- Breastfeeding:
  - The Food and Drug Administration (FDA) and American Academy of Pediatrics (AAP) have each released recommendations for breastfeeding after a mother has been exposed to radiation. The FDA's recommendation is a mother can breast feed after she has been treated with KI. The AAP recommends that mothers do not breast feed, even if they have been treated with KI unless no other alternative is available. For more information or assistance with determining if breast feeding should continue, consult the Pediatric Care Medical Specialist and/or REAC/TS.

ATTACHMENT 19: PEDIATRIC BURN CARE GUIDELINES

Prussian Blue

Prussian Blue is utilized when the source is cesium, rubidium or thallium. The dosing recommendations are:

- Children 2-12 years old: 1 gm PO TID
- Children >13 years old: 3 gm PO TID

Approximate Thresholds for Acute Radiation Syndromes

Dose		Signs/Symptoms*
0-100 rads (0-1 Gy)	NA	Generally asymptomatic, potential slight drop in lymphocytes later (near 1 Gy)
> 100 rads (> 1 Gy)	Hematopoietic	Anorexia, nausea, vomiting, initial granulocytosis and lymphocytopenia.
> 6-800 rads (> 6-8 Gy)		Early severe nausea, vomiting, watery diarrhea, pancytopenia
> 2000 rads (> 20 Gy)	Cardiovascular/ CNS	Nausea/vomiting within first hour, prostration, ataxia, confusion

* At higher doses the time to onset of signs/symptoms may be compressed.

Psychological Considerations

Radiation emergencies, whether it be from a leak at a nuclear power plant or from a terrorist type incident such as a dirty bomb, leads to significant public anxiety. The anxiety associated with such events can appear out of proportion to the radiation induced health effects and can greatly affect the entire community. Many patients may present with symptoms such as nausea. It is important for providers to determine if nausea is from contamination or from the anxiety of the event. Long term psychological effects can manifest years after an event. General examples of long term effects include: feelings of vulnerability, PTSD, chronic anxiety, feelings of loss of control, fear of safety and health of themselves as well as future generations, and multiple idiopathic physical symptoms (MIPS). Provide educational materials and counseling options to all patients and their families after a radiological emergency.

Radioactive Contamination versus Exposure

- Radioactive contamination: radioactive material is on or inside a person
  - External contamination-radioactive material is only on outside of a person
  - Internal contamination-radioactive material is ingested, inhaled, or absorbed through the skin or open wound
- Radiation exposure: a person is exposed to radioactive materials
- Difference between contamination and exposure:
  - Person exposed to radiation may not be contaminated. An radiation exposure means radioactive material penetrated the person's body. For a person to be contaminated with radioactive materials, the materials must be on or inside of the person's body.

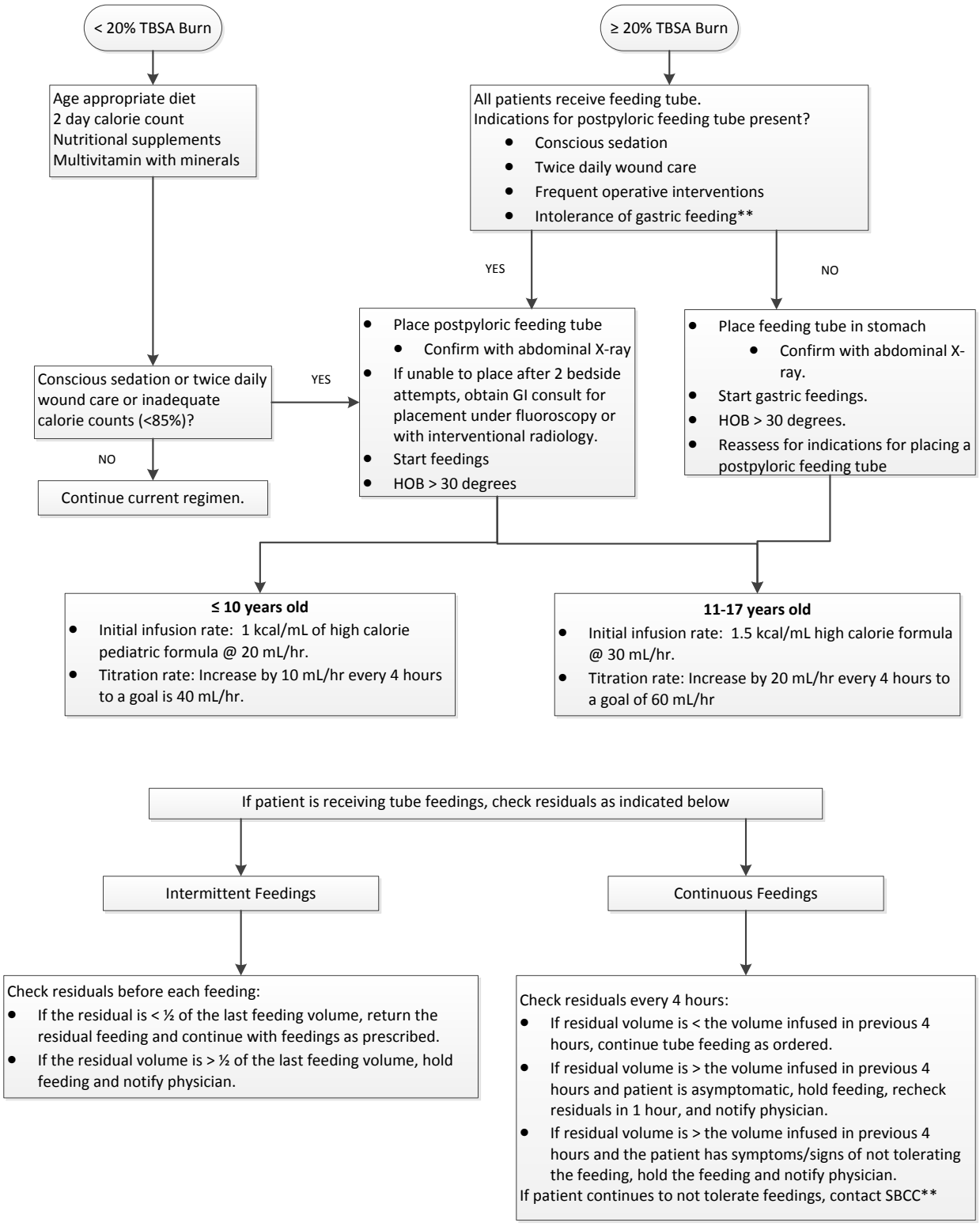
ATTACHMENT 19: PEDIATRIC BURN CARE GUIDELINES

General Information about Radiological Decontamination

- Typically is not emergently needed as compared to chemical decon
  - ***Can begin treatment for life threatening conditions before initiating decon***
  - Low risk to health care providers if decon is delayed
- Radioactive material cannot be neutralized, only moved from one point to another
- Clean dry sheet or drapes should be applied to the area to prevent spread of contamination to uncontaminated areas
- Standard pediatric considerations for decontamination apply:
  - Use warm water (98°-110°F)
  - Do not carry infants/young children through decon shower
  - Have rewarming measures available after decon is completed
- Clean wound via baby wipes or via irrigation
  - Options: baby wipes, irrigation, OR soft cloth with soap and tepid water
- Irrigation:
  - Irrigate would/orifice/area with sterile saline or equivalent
  - Prevent splashing
- Run-off should be directed into a receptacle (i.e. lined garbage can)
  - Keep all waste (run-off, absorbent pads, sheets, towels) for later collection and disposal
- Repeat until no further contamination is noted.
- Minor debridement may be needed if wound has foreign bodies in it
- After decon completed, clean wound as per hospital protocol.
- Other considerations:
  - Partial thickness burns:
    - Always irrigate
    - Leave blisters closed
    - Irrigate open blisters
  - Full thickness burns:
    - Radioactive contaminate will slough in eschar
    - Contaminates will remain in layers of dead tissue

ATTACHMENT 19: PEDIATRIC BURN CARE GUIDELINES

Nutritional Algorithm for Pediatric Burn Patients



** Intolerance of feedings can be a sign of sepsis in burn patients

ATTACHMENT 20: RECOMMENDED BURN SUPPLY CACHE

Purpose: Provide health care facilities, regions and the state with a standardized list of burn supplies that can be utilized during a burn MCI.

Instructions: This list should be used to develop a burn supply cache at the individual health care facility, regional and state level to care for a projected number of patients that may seek medical care during a burn MCI. The supplies on this list will address the needs of 10 burn patients over a 24 hour timeframe.

Recommended Burn Cache Supplies for 10 Patients

Supplies

- Large burn dressings 24" X 36" — 100
- Small burn dressings 18" x 18" — 100
- Rolled dressing 4' x 3 yard roll — 200
- Super sponges (6 x 6) — 500 packages
- Flexible net dressings
  Sizes: 1, 3, 5, 8, 10 — 10 boxes for each size
- Non-stick dressing small — 40
- Non-stick dressing large — 40
- All-purpose solution bowls — 40
- Sterile fields — 100
- Lactated Ringers (LR) — 200
- Intubation supplies
- Bandage scissors
- Central line kits
- Arterial line kits
- Urinary catheters (various sizes for all ages)
- NG tubes (various sizes for all ages)

Medications

- Bacitracin 400 g jar — 20
- Silver sulfadiazine (Silvadene) 400 g jar — 40
- Morphine (may be part of hospital's disaster pharmaceutical cache)
- Silver antimicrobial barrier dressings — 100
  (e.g., Acticoat, Mepilex). These are recommended for burn hospitals only since they have the ability to rotate these items into daily use to avoid expiration.

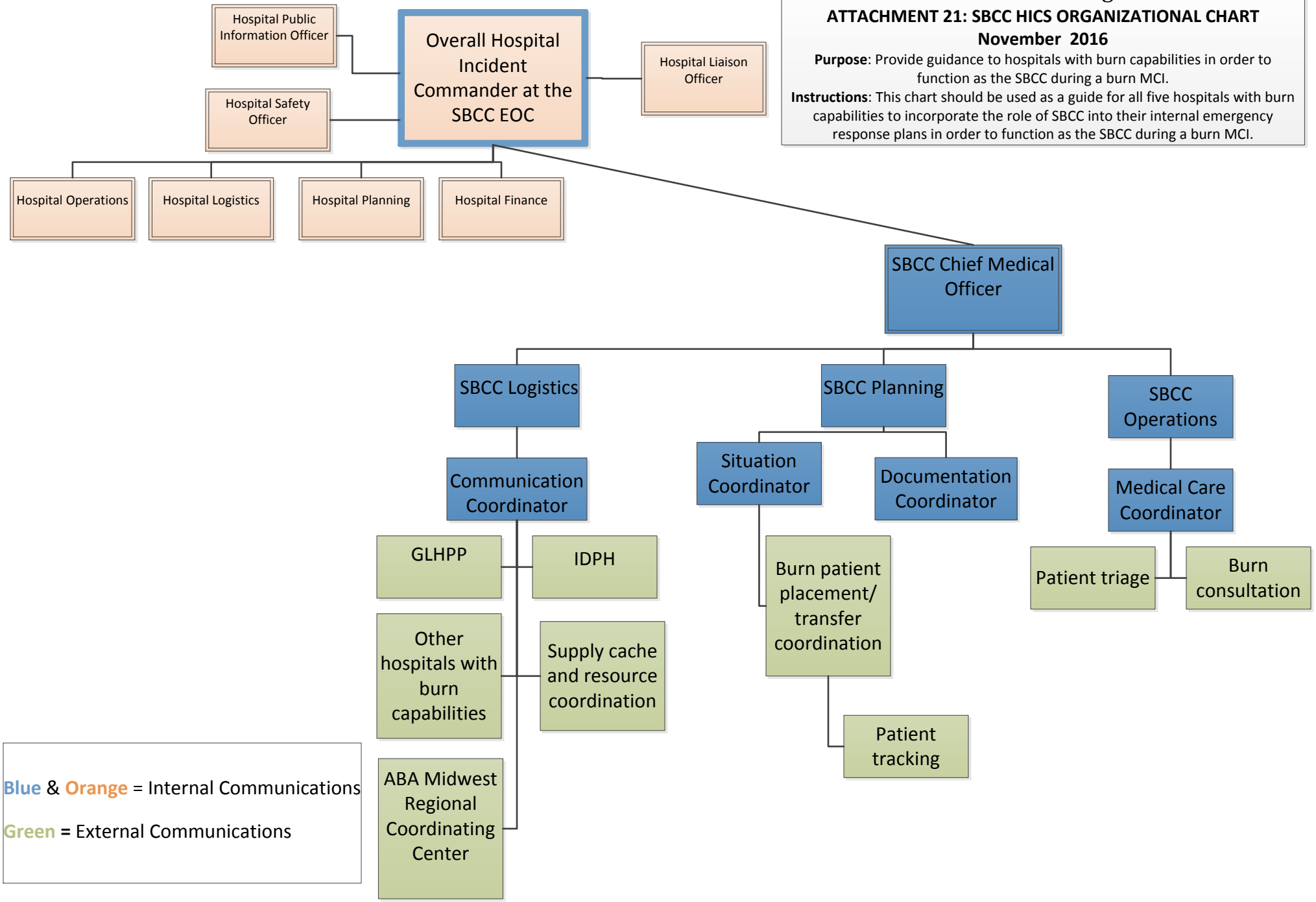
IDPH ESF-8 Plan: Burn Surge Annex **2016**

ATTACHMENT 21: SBCC HICS ORGANIZATIONAL CHART

November 2016

Purpose: Provide guidance to hospitals with burn capabilities in order to function as the SBCC during a burn MCI.

Instructions: This chart should be used as a guide for all five hospitals with burn capabilities to incorporate the role of SBCC into their internal emergency response plans in order to function as the SBCC during a burn MCI.



ATTACHMENT 22: SBCC JOB ACTION SHEETS

Purpose: Provide guidance to Illinois hospitals with burn capabilities in order to function in the role of SBCC during a burn MCI.
Instructions: These job action sheets should be incorporated into the incident command system/emergency operations center response functions at all five hospitals with burn capabilities to, assist each with functioning as the SBCC during a burn MCI.

SBCC Chief Medical Officer

Mission

Organize and direct overall response as the State Burn Coordinating Center (SBCC), including communication, burn consultation, patient triage, patient placement/transfer, patient tracking and documentation in the event of a mass casualty incident involving multiple burn victims. Directs all staff about duties related to the SBCC role.

Recommended primary provider to fill this role

Burn attending on-call

Date _____ Start _____ End _____ Position Assigned to _____ Initial _____

Position Reports to _____ Signature _____

Location □ Hospital EOC □ Hospital Unit _____ □ Remote (via phone, radio, etc.)

Phone (1) _____ Phone (2) _____ Fax _____

Other Contact Information_____ Radio Title _____

ACTIVATION PHASE	TIME	INITIAL
Upon activation of the IDPH ESF-8 Plan: Burn Surge Annex, the SBCC will be notified by IDPH through the pre-designated method.		
SBCC may be notified directly by another hospital or GLHPP about a mass casualty incident involving multiple burn victims.		
Once notification is received, the SBCC chief medical officer will be notified as indicated in the SBCC internal burn surge plan.		

IMMEDIATE OPERATIONAL PERIOD (0-2 hours)	TIME	INITIAL
Initiate SBCC internal burn surge plan.		
Notify administrator on call, if not already aware, who will activate the emergency operations center.		
If notified by hospital or GLHPP regarding event, notify IDPH and request Burn Surge Annex activation.		
Obtain a briefing on incident and status of operation and response from IDPH.		
Assign additional SBCC medical staff resources, as needed.		
Activate additional SBCC roles, as indicated. • SBCC logistics: Communication coordinator • SBCC operations: Medical Care coordinator • SBCC planning: Situation coordinator • SBCC planning: Documentation coordinator		
Obtain status report from: • SBCC logistics: Communication coordinator regarding status of event, supply cache		

capabilities, status of GHLPP's and CDPH resources. • SBCC operations: Medical care coordinator regarding current patient triage and consultation needs throughout the state. • SBCC planning: Situation coordinator regarding patient tracking and current bed availability at all hospitals with burn capabilities. • SBCC planning: Documentation coordinator regarding maintaining proper documentation of the incident and response.		

INTERMEDIATE OPERATIONAL PERIOD	TIME	INITIAL
Assist staff with triaging burn requests and coordination of burn patients' transfers from the hospital of initial management to the appropriate burn category hospital based on triage criteria in the Burn Surge Annex and available resources.		
Provide burn consultation on the management of patients at hospitals without burn capabilities during the initial 72 hours post incident.		
Maintain communication with IDPH through the Hospital Unit Lead in the PHEOC for routine briefings on status of the event, resource availability, resource needs, triage and transfer coordination, triage and consultation needs.		
Maintain communication with internal staff and incident command.		
Monitor for completion of event documentation.		
Provide briefings to staff on status of event.		

EXTENDED OPERATIONAL PERIOD	TIME	INITIAL
Coordinate the triage, transfer and tracking of burn patients in and out of state.		
Provide burn consultation on the management of patients at non-burn hospitals during the initial 72 hours post incident through available communication methods (e.g. phone, secure email, telemedicine via facility system, Illinois Homeland Security Information Network (HSIN) Burn Disaster virtual room).		
Monitor staff for signs of stress and relieve, as necessary.		
Review event documentation.		
Shift change: Brief replacement on the status of all ongoing burn consultation, triage, and transfer needs.		

DEMOBILIZATION/RECOVERY	TIME	INITIAL
Participate in debriefing after event (internal and with IDPH).		
Review event and post-event documentation.		
Contribute to and review after action report for lessons learned and improvement plans.		
Assist with implementing the improvement plan.		

DOCUMENTS/TOOLS
• Burn Surge Annex • Attachment 5: Burn Medical Incident Report Form • Attachment 6: Burn Communication Pathway • Attachment 23: Burn Patient Casualty Communication Log • Attachment 24: Post Event Data Collection Log

SBCC Logistics: Communication Coordinator

Mission
To maintain and coordinate communication between key stakeholders (e.g., IDPH, GLHPP, hospitals with burn capabilities) regarding the mass casualty incident involving multiple burn victims and the overall status of burn resources throughout the state and with border states.

Recommended primary provider to fill this role
Emergency preparedness coordinator

Date _____ Start _____ End _____ Position Assigned to _____ Initial _____

Position Reports to _____ Signature_____

Location □ Hospital EOC □ Hospital Unit _____ □ Remote (via phone, radio, etc.)

Phone (1) _____ Phone (2)_____ Fax _____

Other Contact Information_____ Radio Title_____

ACTIVATION PHASE	TIME	INITIAL
Upon activation of the SBCC due to a mass casualty incident involving multiple burn victims, the SBCC chief medical officer will activate the SBCC logistics: Communication coordinator, as indicated.		

IMMEDIATE OPERATIONAL PERIOD (0-2 hours)	TIME	INITIAL
Obtain briefing of incident and status of plan from SBCC chief medical officer.		
If needed, assemble additional staff and assign duties.		
Identify primary contact and method of contact for key stakeholders.		
Contact key stakeholders for situational awareness status update.		

INTERMEDIATE OPERATIONAL PERIOD	TIME	INITIAL
Provide SBCC chief medical officer with status updates		
Provide SBCC planning: Situation coordinator and SBCC operations: Medical care coordinator with status updates, resource availability at all burn category Hospitals, patient triage, patient placement/transfer and burn consultation requests as they are received.		
Communicate to and receive updates from key stakeholders.		
Monitor fax and other communication devices for incoming status updates, patient triage, patient placement/transfer and burn consultation requests.		
Troubleshoot communication needs.		

EXTENDED OPERATIONAL PERIOD	TIME	INITIAL
Continue to communicate with key stakeholders.		
Continue to provide status updates, resource availability, patient triage request and burn consultation requests as they are received.		

ATTACHMENT 22: SBCC JOB ACTION SHEETS

Continue to monitor communication devices for incoming status updates and requests.		
Continue to troubleshoot communication needs.		
Monitor staff for signs of stress and relieve as necessary.		
Shift change Brief replacement on the status of all ongoing communication needs and issues. Brief replacement on method to contact key stakeholders.		

DEMOBILIZATION/RECOVERY	**TIME**	**INITIAL**
Provide SBCC chief medical officer a status report.		
Participate in debriefing after event (internal) and provide feedback on lessons learned.		
Complete required event and post-event documentation.		

DOCUMENTS/TOOLS
• Burn Surge Annex • Attachment 5: Burn Medical Incident Report Form • Attachment 6: Burn Communication Pathway • Attachment 7: Kentucky Resource Request Process • Attachment 8: Missouri Resource Request Process • Attachment 11: Illinois Burn Resource Directory • Attachment 23: Burn Patient Casualty Communication Log

ATTACHMENT 22: SBCC JOB ACTION SHEETS

SBCC Operations: Medical Care Coordinator

Mission
To facilitate the receipt, response, coordination and communication of patient triage and consultation need requests between burn experts at the SBCC, IDPH and hospitals without burn capabilities throughout the state.

Recommended provider to fill this role
Burn/trauma residents and burn/trauma nurse practitioners

Date _____ Start _____ End _____ Position Assigned to _____ Initial_____

Position Reports to _____ Signature _____

Location □ Hospital EOC □ Hospital Unit _____ □ Remote (via phone, radio, etc.)

Phone (1) _____ Phone (2) _____ Fax _____

Other Contact Information_____ Radio Title _____

ACTIVATION PHASE	TIME	INITIAL
Upon activation of the SBCC due to a mass casualty incident involving multiple burn victims, the SBCC chief medical officer will activate the SBCC operations: Medical care coordinator as indicated.		

IMMEDIATE OPERATIONAL PERIOD (0-2 hours)	TIME	INITIAL
Obtain briefing of incident and status of plan from SBCC chief medical officer.		
Collaborate with SBCC logistics: Communication coordinator regarding patient triage and patient placement/transfer requests and burn consultation requests.		
If needed, assemble additional staff and assign duties.		
• Become familiar with documentation tools (e.g., Attachment 5: Burn Medical Incident Report Form; Attachment 15: Hospital Burn Triage Guidelines; Attachment 13: Burn Patient Tracking Log; Attachment 23: Burn Patient Casualty Communication Log).		
Identify any outstanding patient triage, burn patient transfer and consultation requests.		

INTERMEDIATE OPERATIONAL PERIOD	TIME	INITIAL
Triage all patient transfer requests utilizing Attachment 15: Hospital Burn Triage Guidelines.		
Collaborate with SBCC planning: Situation coordinator regarding triage decisions to assist with patient placement and transfer coordination to the appropriate burn category hospital.		
Address burn consultation needs and requests from hospitals with no burn capabilities.		
Communicate with SBCC chief medical officer regarding triage requests and burn consultation requests.		
Document communication regarding triage requests and burn consultations on the appropriate forms (Attachment 23: Burn Patient Casualty Communication Log).		

ATTACHMENT 22: SBCC JOB ACTION SHEETS

EXTENDED OPERATIONAL PERIOD	TIME	INITIAL
Continue to triage all patient transfer requests.		
Continue to collaborate with SBCC planning: Situation coordinator regarding triage decisions.		
Continue to document communications regarding triage requests, patient placement requests and burn consultations on the appropriate forms.		
Continue to update SBCC chief medical officer.		
Monitor staff for signs of stress and relieve as necessary.		

DEMOBILIZATION/RECOVERY/SHIFT CHANGE	TIME	INITIAL
Brief replacement on the status of all ongoing/outstanding triage and burn consultation needs.		
Provide SBCC chief medical officer a status report.		
Participate in debriefing after event (internal) and provide feedback on lessons learned.		
Complete required event and post-event documentation.		

DOCUMENTS/TOOLS
• Burn Surge Annex • Attachment 5: Burn Medical Incident Report Form • Attachment 13: Burn Patient Tracking Log • Attachment 15: Hospital Burn Triage Guidelines • Attachment 18: Adult Burn Guidelines • Attachment 19: Pediatric Burn Guidelines • Attachment 23: Burn Patient Casualty Communication Log

SBCC Planning: Situation Coordinator

Mission
To obtain and maintain current bed availability at all hospitals with burn capabilities to assist with patient placement during a mass casualty incident with multiple burn victims and provide patient tracking for those burn patients that the SBCC coordinates their transfer/placement between hospitals.

Recommended primary provider to fill this role
Clinical support staff

Date _____ Start _____ End _____ Position Assigned to _____ Initial _____

Position Reports to: _____ Signature: _____

Location □ Hospital EOC □ Hospital Unit _____ □ Remote (via phone, radio, etc.)

Phone (1) _____ Phone (2) _____ Fax _____

Other Contact Information_____ Radio Title _____

ACTIVATION PHASE	TIME	INITIAL
Upon activation of the SBCC due to a mass casualty incident involving multiple burn victims, the SBCC chief medical officer will activate the SBCC planning: Situation coordinator, as indicated		

IMMEDIATE OPERATIONAL PERIOD (0-2 hours)	TIME	INITIAL
Obtain briefing of incident and status of plan from SBCC chief medical officer.		
Collaborate with SBCC operations: Medical care coordinator regarding the status of patient triage and transfer requests for all burn category hospitals.		
If needed, assemble additional staff and assign duties.		
Become familiar with documentation tools (e.g., Attachment 13: Burn Patient Tracking Log).		
Collaborate with SBCC logistics: Communication coordinator regarding bed availability and status of other available resources at all burn category hospitals.		

INTERMEDIATE OPERATIONAL PERIOD	TIME	INITIAL
Collaborate with SBCC operations: Medical care coordinator to obtain triage decisions and track all patient placement and transfers coordinated through the SBCC.		
Document patient placement/transfers coordinated through the SBCC on the Burn Patient Tracking Log.		
Collaborate with SBCC logistics: Communication coordinator to obtain updates on resource availability to assist with burn patient placement and transfer coordination.		
Collaborate with SBCC logistics: Communication coordinator to communicate with IDPH		

regarding burn patient placement and transfer coordination.		
Coordinate with hospitals with burn capabilities to place patients triaged as Category 1 at a hospital with burn capabilities.		
Coordinate with Level I trauma centers/non-burn hospitals to place patients triaged as Category 2 and any patients triaged as Category 1 that are unable to be placed at a hospital with burn capabilities at an appropriate facility.		
Coordinate with Level II trauma centers/non-burn hospitals to place patients triaged as Category 2 at an appropriate facility.		
Coordinate with any acute care non-burn hospital with an intensive care unit and ventilator capabilities to place patients triaged as Category 3 at an appropriate facility.		
Coordinate with non-trauma/non-burn hospitals to place patients triaged as Category 4 and Category 5 at an appropriate facility.		
Communicate with SBCC chief medical officer regarding triage requests, patient placement and burn consultation requests.		

EXTENDED OPERATIONAL PERIOD	**TIME**	**INITIAL**
Continue to coordinate burn patient transfers with all burn category hospitals.		
Continue to collaborate with SBCC operations: Medical care coordinator regarding triage decisions.		
Continue to collaborate with SBCC logistics: Communication coordinator to obtain resource availability status updates and to assist with communication with IDPH.		
Continue to document all patient placement/transfers that are coordinated through the SBCC on the Burn Patient Tracking Log (Attachment 13).		
Continue to update SBCC chief medical officer		
Monitor all staff for signs of stress and relieve as necessary		

DEMOBILIZATION/RECOVERY/SHIFT CHANGE	**TIME**	**INITIAL**
Brief your replacement on the status of ongoing/outstanding patient placement needs.		
Provide SBCC chief medical officer a status report.		
Participate in debriefing after event (internal) and provide feedback on lessons learned.		
Complete any required event and post-event documentation (e.g., Attachment 24: Post Event Data Collection Log)		

DOCUMENTS/TOOLS
• Burn Surge Annex • Attachment 5: Burn Medical Incident Report Form • Attachment 13: Burn Patient Tracking Log • Attachment 15: Hospital Burn Triage Guidelines • Attachment 23: Burn Patient Casualty Communication Log • Attachment 24: Post Event Data Collection Log

SBCC Planning: Documentation Coordinator

Mission
To maintain and assist others with maintaining proper documentation during and after a mass casualty incident involving multiple burn victims

Recommended primary provider to fill this role
Unit secretaries, administrative assistants

Date _____ Start _____ End _____ Position Assigned to _____ Initial _____

Position Reports to _____ Signature _____

Location □ Hospital EOC □ Hospital Unit _____ □ Remote (via phone, radio, etc.)

Phone (1) _____ Phone (2) _____ Fax _____

Other Contact Info _____ Radio Title _____

ACTIVATION PHASE	TIME	INITIAL
Upon activation of the SBCC due to a mass casualty incident involving multiple burn victims, the SBCC chief medical officer will activate the SBCC planning: Documentation coordinator as indicated.		

IMMEDIATE OPERATIONAL PERIOD (0-2 hours)	TIME	INITIAL
Obtain briefing of incident and status of plan from SBCC chief medical officer.		
If needed, assemble additional staff and assign duties.		
Become familiar with documentation tools (e.g., Attachment 13: Burn Patient Tracking Log, Attachment 17: Burn Patient Transfer Form, Attachment 23: Burn Patient Casualty Communication Log, Attachment 24: Post Event Data Collection Log).		

INTERMEDIATE OPERATIONAL PERIOD	TIME	INITIAL
Collaborate with SBCC chief medical officer to assist with documentation needs.		
Collaborate with SBCC logistics: Communication coordinator to assist with documentation needs.		
Collaborate with SBCC planning: Situation coordinator to assist with documentation needs.		
Collaborate with SBCC operations: Medical care coordinator to assist with documentation needs.		
Communicate with SBCC chief medical officer regarding documentation issues/needs.		

ATTACHMENT 22: SBCC JOB ACTION SHEETS

EXTENDED OPERATIONAL PERIOD	TIME	INITIAL
Continue to collaborate with SBCC chief medical officer to assist with documentation needs.		
Continue to collaborate with SBCC logistics: Communication coordinator to assist with documentation needs.		
Continue to collaborate with SBCC planning: Situation coordinator to assist with documentation needs		
Continue to collaborate with SBCC operations: Medical care coordinator to assist with documentation needs		
Continue to Communicate with SBCC chief medical officer regarding documentation issues/needs.		
Monitor staff for signs of stress and relieve, as necessary.		

DEMOBILIZATION/RECOVERY/SHIFT CHANGE	TIME	INITIAL
Brief your replacement on the status of ongoing/outstanding patient placement needs.		
Provide SBCC chief medical officer a status report.		
Participate in debriefing after event (internal) and provide feedback on lessons learned.		
Complete any required event and post-event documentation (e.g., Post Event Data Collection Log).		
File all event and post-event documentation as per hospital policy.		
Collaborate with SBCC logistics: Communication coordinator to identify method of submitting event and post-event documentation to IDPH.		

DOCUMENTS/TOOLS
• Burn Surge Annex • Attachment 5: Burn Medical Incident Report Form • Attachment 13: Burn Patient Tracking Log • Attachment 17: Burn Patient Transfer Form • Attachment 23: Burn Patient Casualty Communication Log • Attachment 24: Post Event Data Collection Log

ATTACHMENT 23: BURN CASUALTY COMMUNICATION LOG

Purpose: Provide a standardized method of tracking communication between health care facilities and the SBCC during a burn MCI.
Instructions: A designated subject matter expert at the State Burn Coordinating Center (SBCC) will complete this form for each contact with other health care facilities (e.g. transfer coordination requests, medical consultation or other burn resource needs). This form should be stored by the SBCC in the same manner as other incident related command documents.
Note: Information contained within this form is confidential and should not be shared, except with those assisting in the care of the patient.

Incident Name:

NAME of PERSON TAKING CALL **DATE OF CALL**

HEALTH CARE FACILITY/AGENCY **TIME OF CALL**

CALLER INFORMATION:

NAME AND TITLE _____

HEALTH CARE FACILITY/AGENCY _____

PHONE _____ **E-MAIL** _____

PATIENT INFORMATION:

NAME _____ **DOB**_____

TRACKING NUMBER (assigned by initial health care facility) _____

% TBSA_____ **TIME OF BURN INJURY**_____

BURN INJURY _____

INTUBATED □ **YES** □ **NO** **VENTILATOR CAPABILITIES AT CALLER FACILITY** □ **YES** □ **NO**

OTHER INJURIES/CO-MORBIDITIES _____

_____

FAMILY /SOCIAL ISSUES _____

FAMILY CONTACT INFORMATION_____

PURPOSE OF CALL:

□ **BURN CONSULTATION** _____

_____

_____

□ **TRANSFER COORDINATION** _____

RESOURCE NEEDS: □ **BURN** □ **ICU** □ **VENTILATOR** □ **PEDIATRIC** □ **PALLIATIVE CARE** □ **FOLLOW UP**
□ **OTHER**_____

□ **TRIAGE REQUEST**

TRIAGE CATEGORY/TYPE OF HEALTHCARE FACILITY NEEDED

- □ **CATEGORY 1: HOSPITAL WITH BURN CAPABILITIES**
- □ **CATEGORY 2: NON-BURN TRAUMA CENTER**
- □ **CATEGORY 3: HOSPITAL WITH ICU CAPABILITIES**
- □ **CATEGORY 4: NON-BURN/NON-TRAUMA CENTER**
- □ **CATEGORY 5: ANY ACUTE CARE HOSPITAL**

OTHER: _____

FORM CONTINUES ON PAGE 2

ATTACHMENT 23: BURN CASUALTY COMMUNICATION LOG

RESPONSE/INFORMATION PROVIDED	**TRANSFER INFORMATION** **RECEIVING HEALTH CARE FACILITY**_____ **LOCATION (CITY)** _____ **DATE/TIME OF TRANSPORT** _____ **METHOD OF TRANSPORT** _____

ADDITIONAL NOTES

ATTACHMENT 24: POST-EVENT DATA COLLECTION LOG

Purpose: Assist with compiling data after a burn MCI that can provide lessons learned and improvements to response plans.
Instructions: A designated subject matter expert at the State Burn Coordinating Center (SBCC) will complete this form on all patients that the SBCC assists with transfer coordination between two health care facilities or provides medical consultation to. This form will be used to evaluate the disposition and outcomes of burn patients when the annex is activated during a burn MCI. Information on this form should then be shared with the Trauma Advisory Council, Burn Advisory Subcommittee in order to thoroughly evaluate the patient care processes within the annex and address any gaps. The SBCC will store it in the same manner as other incident related command documents.

Incident Name:										
TRACKING NUMBER (assigned by initial health care facility)	**AGE**	**GENDER**	**%TBSA**	**BURN INJURY LOCATION** **BURN INJURY DEPTH**	**INHALATION INJURY**	**OTHER INJURY (Trauma)**	**C0-MORBITITIES**	**# of SURGERIES**	**LOCATION RECEIVED TREATMENT**	**FINAL DISPOSITION**
		M **F**			Y N				□ Hospital with burn capabilities □ Level I trauma/ Non-burn hospital □ Level II trauma/ Non-burn hospital □ Non-burn/Non-trauma hospital □ Outpatient	□ Discharged □ Home □ Nursing home □ Assisted living □ Transfer □ Another hospital □ Acute rehab □ Expired □ AMA
		M **F**			Y N				□ Hospital with burn capabilities □ Level I trauma/ Non-burn hospital □ Level II trauma/ Non-burn hospital □ Non-burn/Non-trauma hospital □ Outpatient	□ Discharged □ Home □ Nursing home □ Assisted living □ Transfer □ Another hospital □ Acute rehab □ Expired □ AMA
		M **F**			Y				□ Hospital with burn capabilities □ Level I trauma/ Non-	□ Discharged □ Home □ Nursing home

ATTACHMENT 24: POST-EVENT DATA COLLECTION LOG

Incident Name:										
TRACKING NUMBER (assigned by initial health care facility)	**AGE**	**GENDER**	**%TBSA**	**BURN INJURY LOCATION** **BURN INJURY DEPTH**	**INHALATION INJURY**	**OTHER INJURY (Trauma)**	**C0-MORBITITIES**	**# of SURGERIES**	**LOCATION RECEIVED TREATMENT**	**FINAL DISPOSITION**
					N				burn hospital □ Level II trauma/ Non-burn hospital □ Non-burn/Non-trauma hospital □ Outpatient	□ Assisted living □ Transfer □ Another hospital □ Acute rehab □ Expired □ AMA
		M **F**			Y N				□ Hospital with burn capabilities □ Level I trauma/ Non-burn hospital □ Level II trauma/ Non-burn hospital □ Non-burn/Non-trauma hospital □ Outpatient	□ Discharged □ Home □ Nursing home □ Assisted living □ Transfer □ Another hospital □ Acute rehab □ Expired □ AMA
		M **F**			Y N				□ Hospital with burn capabilities □ Level I trauma/ Non-burn hospital □ Level II trauma/ Non-burn hospital □ Non-burn/Non-trauma hospital □ Outpatient	□ Discharged □ Home □ Nursing home □ Assisted living □ Transfer □ Another hospital □ Acute rehab □ Expired □ AMA